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SCI. MED. DIV.

addictions

vol. 14-15

SPRING, 1967-68

WINTER

MAY 1 1967



Volume 14, Number 1

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ADDICTIONS is published four times a year by the Addiction Research Foundation, an agency of the Province of Ontario.

The contents of each issue are selected on the basis of their potential interest to persons engaged in research, treatment or education in the field of alcoholism and drug addiction.

Articles published in ADDICTIONS do not necessarily reflect the view of the Foundation.

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A.I.T. Addictions

Volume 14, Number 1

Spring, 1967

Point Zero Eight

—CTV's film special on drinking-driving test

A drinking-driving test conducted for a network television film special, CTV's *Point Zero Eight*, has cast further doubt on the view that .08 per cent can safely be taken as the minimum blood alcohol level that should legally constitute impairment.

H. Ward Smith, Ph.D., director of the Ontario government's Centre of Forensic Sciences,* who directed the test last November for the privately-owned network, said in the film that his findings had made him change his own mind about the minimum danger level.

Prof. Smith had appeared as an expert witness in the spring of 1966 before a House of Commons committee that was considering the Canadian Bar Association's proposal to establish .08 per cent as the legal impairment level. At that time, he told narrator Ed McGibbon, he believed that .10 was the lowest level that could be documented according to the available scientific data as certain to include all those impaired; he believed that the available data would not support .08 as indicating impairment in most drivers. After evaluating the results of the test, he appeared before the committee again at his own request

* And an Associate Professor of Pharmacology at the University of Toronto.

to say that he now believed that .08 was probably too high, and that a safer minimum would be .05.

The difference between .05 and .08 per cent, in terms of alcohol consumed, is just about the difference between two and three drinks. If a 160-pound man were to drink two ordinary-size drinks—of beer, wine or hard liquor—in a few minutes, his blood alcohol level would rise to just about .05 per cent; if he made his two drinks last an hour, his level would stay down well below .05—closer to .03, which is not considered to impair most drivers.

Chugalug does it

If he were to take three drinks in a few minutes, his blood alcohol level would soar to nearly .08; he would have to space the three drinks over about two hours to keep it below .05. Four drinks would give him a blood alcohol level of about .10 if he drank them one on top of the other; he would have to make four drinks last about three-and-a-half hours to keep it below .05.

Prof. Smith told us that the idea for the *Point Zero Eight* film originated when CTV representatives asked him if he would design a demonstration that they could film for television to illustrate the effects of drinking on drivers. In a report of the tests, issued by CTV as a handout, Prof. Smith said: "The unique features of this study are that racing drivers were used and speeds of up to 60–70 miles per hour formed part of the tests."

Prof. Smith and an assistant, D. M. Lucas, M.Sc., collaborated with Paul Cooke, manager of the Canadian Comstock Racing Team, to devise a series of tests that would show "changes in judgment, attitude and skill." They set up the course at Harewood Acres Race Track, on the site of the wartime RCAF station at Jarvis, Ontario, about twenty miles southeast of Brantford.

"Racing drivers were used," Prof. Smith said in his report, "because it was thought that at the concentrations of alcohol involved, their skill would not be so markedly affected that they

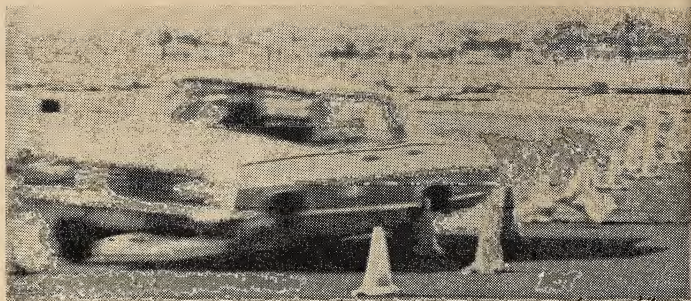
ould get into a serious accident situation. The tests were scored on a two-page sheet which listed some fifty items, which indicated various departures from the ideal driving pattern. Mr. Cooke was able to get two skilled drivers and racing instructors who, with himself, formed a team of three observers. These were Bob Hanna and Richard Shelton. The drivers were Al Leese, Werner Gudzus, Ludwig Heimrath, Ian Hart, Lloyd Howell, Craig Hill, Diana Carter, and Zigrund Gudzus. These drivers have all won trophies consistently in Canadian racing.

"The procedure was to have the drivers, after being instructed to drive safely and within their limits, drive the track several times for practice. They drove the two-mile track four times, what we referred to as the 'dry runs,' on which they were scored. They were then interviewed to determine their drinking history and to assess how much alcohol it would be safe to give them in relation to their stated tolerance. They then drank the amount agreed on in a one-hour period. An additional hour elapsed so that this alcohol would be absorbed. They went back on the track and drove the track four more times, which we refer to as the 'wet run.' The alcohol level was measured before and after the 'wet runs' using the Breathalyzer.

Three more for the road

"Some of these drivers were re-tested so that after their 'wet runs,' they came back to the refreshment stand, drank for another hour, allowing an hour for absorption of alcohol, and were tested at various higher levels. It was thought that this arrangement would allow for a suitable measure of driving skill normal to this situation, and a suitable test of any change after alcohol.

"In summary, the results were dramatic and showed things which we had no reason to expect. The most notable finding appeared to be a failure to sense the attitude or position of the car. This showed especially on curves, and is connected with the deep muscle sense which is the balancing mechanism of the body. Since there was a reduction in this feeling, the driver



—CTV Photo

reacted to visual clues, which only come after something has happened. Therefore his driving response is late and usually exaggerated. This gives a weaving, and at a speed a choppy action of the car. This occurred to some extent at all levels studied down to a reading of .04 per cent.

“In this study, changes in driving ability were shown in all of the drivers at levels between .04 and .08 per cent. With three drivers they were taken to higher levels of .10, .13 and .15 per cent. The results at these higher levels were even more prominent in terms of impairment in driving ability.

“In addition to the loss of deep muscle sense, there were general observations in all of the subjects. These have been summarized by Mr. Cooke who was in charge of the small team of observers. These include an increase in speed; an over-application of brakes; a tendency to wander out of their lane; misjudgment of their distances when stopping and turning; an inability to quickly cancel any reaction when started; more easily distracted; and inability to sense speed except when accelerating. There was also a general complaint that things were happening too fast. This was apparent in all, in that they appeared to be driving behind the car rather than ahead of it. This is notable because racing drivers need to plan far ahead of the car and are quite accustomed to doing this.”

The driving behaviour Mr. Cooke observed from his position

beside the driver bears some resemblance to the driving behaviour that suggests impairment to the trained police patrol officer on the highway. A pamphlet called *The Way to Go*, published by the Kemper Insurance Group of Chicago, quotes instructions issued to the California Highway Patrol. These are the deviations from normal driving they are instructed to watch for:

- driving unreasonably fast; driving unreasonably slowly; driving in spurts—slowly, then fast, then slowly;
- frequent lane-changing with excessive speed;
- improper passing with insufficient clearance; taking too long or swerving too much in passing—this suggests over-control;
- overshooting or disregarding traffic control signals; approaching signals unreasonably fast or slowly, and stopping or attempting to stop with uneven motion;
- driving at night without lights; delay in turning lights on when starting from a parked position; failure to dim lights to oncoming traffic;
- driving in lower gears without apparent reason, or repeatedly clashing gears;
- jerky starting or stopping;
- driving too close to shoulders or curbs, appearing to hug the edge of the road, or continually straddling the centre-line;
- driving with windows down in cold weather; and driving or riding with head partly or completely out of the window.

A tough course

Paul Cooke told us that the test course had been set up to a standard of difficulty that would ensure that the best of the test drivers would make some errors, even on the dry runs. This ensured a meaningful scoring spread for the drivers on the dry runs. On the wet runs, the skill of the drivers was such that a meaningful scoring spread could still be obtained. He said that the average driver would probably have done as badly on the dry runs as the test drivers did on the wet runs, and would probably not have completed the wet runs at all.

Because all the drivers made some errors on the dry runs, the errors they made on the wet runs did not signal to them that they were not doing as well; in fact, all the drivers thought they had done just as well on the wet runs—even those who had committed the grossest errors—until they were confronted with their scores on paper. The observers who rode with them were under no such illusion. Paul Cooke had been sure that his picked team of top drivers would not respond to alcohol, but when he stepped into a car on the first of the wet runs, “I realized I’d made a mistake.”

An incredible difference

One driver’s blood alcohol level was raised to .15—dangerous beyond argument, but not uncommon as parties are breaking up or bars closing: .15 represents the effect, in a 160-pound man, of eight drinks over four hours. At .15, the test driver, who remained aggressively confident throughout, was so obviously intoxicated that his regular observer refused to ride with him: he was grandstanding, cutting tight figure-eights on the tarmac beside the pits. Against the advice of Prof. Smith, Paul Cooke volunteered to ride around the course with him, and reported that the difference in his driving was “incredible”—the most outstanding characteristic being his “disregard for his own safety.”

Prof. Smith emphasized that throughout the wet runs it was the reserve of superlative skill that these top drivers retained, even while intoxicated, that saved them from real trouble; most ordinary drivers subjected to the same tests would have got into an accident.

Prof. Smith said in his report that the results of the tests “have a bearing on the legislation proposed by the Canadian Bar Association of .08 per cent as a level at which a driver would be guilty of an offense. These results indicate that this is probably too high a level. Should additional studies support these findings, the permissible level probably should not be higher than .05 per cent. This is in line with a recommendation by the

British Medical Association Advisory Committee in 1960 which indicated that 'The Committee considers the concentration of .05 per cent of alcohol in the blood while driving a motor vehicle is the highest that can be accepted as entirely consistent with the safety of other road users.'

"It is also in line with the recommendation of an International Symposium on Accident and Traffic Medicine whose expert committee resolved 'that in no circumstances could a blood alcohol concentration in excess of .05 per cent be permitted in drivers of motor vehicles on the public highway.'

"This is also in line with the current legislation in Norway, which has been in effect since 1926, of .05 per cent as an offense.

"It is also in line with early studies done in Toronto in 1950 in which it was shown that levels of .03-.05 per cent of alcohol began to be a factor in personal injury accidents."

Studied police reports

The Toronto study Prof. Smith referred to is one in which he collaborated with Robert Popham, M.A., now Associate Research Director (Behavioural Studies) at this Foundation. The study was called "Blood Alcohol Levels in Relation to Driving" and was published in the October, 1951, issue of the *Canadian Medical Association Journal*. The authors studied police reports, including breath samples, from personal-injury motor vehicle accidents in Toronto over a three-month period. They said their data indicated that the minimum concentrations of alcohol that are important in actual driving situations are in the range of 0.03 to 0.05 parts per hundred (.03-.05 per cent).

"From the available evidence," they said, "It appears quite reasonable to *presume* [italics are the authors'] that most drivers are not significantly affected by concentrations of alcohol less than 0.05 parts per hundred and that all drivers with concentrations of 0.15 parts per hundred [.15 per cent] or higher are affected. . . . It is suggested that evidence of blood alcohol concentrations of 0.05 parts per hundred or higher, together with evidence of driving errors, may be sufficient to designate

those drivers who may be presumed to be affected by alcohol.”

The legislation recommended by the Canadian Bar Association would make unlawful the driving of a motor vehicle by a person with a blood alcohol level to be fixed by the legislation, provided that the level should not be less than .08 per cent. Full text of the proposal was given by Prof. E. R. Alexander in his article, “Responsibility and Addiction: The Law in Canada,” in the Winter, 1966, issue of *Addictions*.

History of .08 proposal

In material that had to be dropped from that issue because of space limitations, Prof. Alexander wrote: “The general membership of the Association rejected this proposal at its annual meeting in September, 1965, but accepted it at the September, 1966, meeting; the Executive Council of the Association then forwarded it to the Minister of Justice, who has it under advisement. . . .

“The Canadian Medical Association had previously recommended legislation making it an offence to drive a motor vehicle with a blood alcohol level of more than .05 per cent. . . . A special committee of the Canadian Society of Forensic Sciences, following their tenth annual meeting in Ottawa, reported: ‘There is indisputable scientific evidence that a car driven by a person who has a blood alcohol level of 0.10 per cent or higher is a danger to others using the roads. However, since impairment of driving occurs in some drivers at a blood alcohol level of 0.05 per cent, this is the highest level that can be accepted as consistent with highway safety.’

“The special committee of the Canadian Bar Association recommended a level of .10 per cent because ‘an unreasonably low level would constitute an unwarranted and unjustified invasion of the rights of the individual. On all the material before it, your Committee is of the opinion that such level should not be lower than .1% or 1.0 parts per thousand of alcohol in venous blood.’ Apparently the Executive Council of the Association chose the level of .08 per cent as a compromise.”

The drinking-driving legislation in Norway is strictly enforced, writes Nils Christie, professor of criminology at the University of Oslo, in the January/February, 1967, issue of *Trans-action*.^{*} After noting that Norway has the lowest legal blood alcohol limit of the Scandinavian countries, Prof. Christie writes: "If a driver's blood test measures above the legal minimum (.05 per cent) in Norway he will, typically, draw 21 days in prison and have his licence suspended for one year on first offense (more on succeeding offenses). . . .

"More than 2000 persons were imprisoned in Norway in 1963 for drunk driving. . . . More people are imprisoned in Norway for drunk driving than for all crimes put together. A sizeable part of the Norwegian people at some time in their lives go through society's most severe ceremony of degradation—imprisonment with criminals."

Severe laws popular

Referring to the severe drinking-driving laws of all the Scandinavian countries, Prof. Christie writes:

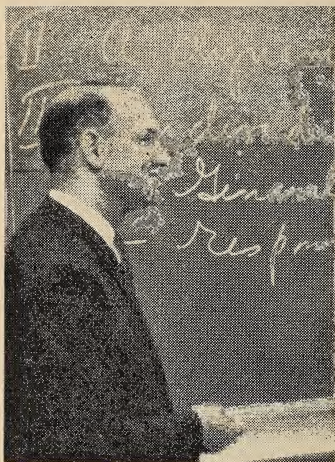
"There is little chance that these laws will be changed—they have strong popular support. Poll after poll show that the people approve of them. Only two groups have serious doubts about them—the drunken drivers themselves and the people who administer the laws. The drunk drivers stay prudently quiet; and the administrators are ambivalent, hampered by a feeling that there are many good things about our present practices.

"For we feel that our present system curtails drinking in general, and drunk driving in particular. Many people don't drive to parties where they expect to find drink, or they don't drink when they get there. Those who do know that they run the risk of getting caught."

^{*}A publication of the Community Leadership Project of Washington University, St. Louis, Missouri.

To Drink or Not to Drink: The Individual's Responsibility

by Jean-Louis Allard, D.Ph.



The story is told about the Greek philosopher, Thales, who was walking along, looking up at the sky, and fell into a well. The people around said, "Instead of scrutinizing the sky, why don't you look where you are walking?" It is from this that people speak of philosophers as people who live in the clouds. I have to disagree: I think there is nothing as practical as a sound philosophy of life. The American philosopher William James wrote: "No one can live an hour without both facts and principles."

I think philosophical reflections are both relevant and important if one wants to have a better understanding of the significance of human life, of human problems and particularly of what concerns us here, the problem of drinking.

I think our civilization is in great need of guiding principles and I would like to present some of them here. It is one point of view, of course, and this point of view on the problem of drinking has to be inserted in a general context, because I think it is very hard to speak of any human problem without having some general ideas concerning man, concerning the meaning of human life and of human life in society. From such a concept of man, both as a person and as a member of society, we will

Jean-Louis Allard is Professor of Philosophy at the University of Ottawa and research advisor to L'Association Lacordaire du Canada, of which he is a past vice-president. This article is adapted from a talk Prof. Allard gave to the Foundation's two-week summer courses in 1965 and 1966.

ry to underline the moral significance of the virtue of sobriety as well as the individual's responsibility towards the problem of drinking.

. A Personalist View of Man

There have been many contrasting views of the nature of man. I would like to present them very simply, not for the sake of condemning them, but to clarify my own position. There is the so-called "angelic concept of man"—it is derived partly from Plato and has been taken up by many philosophies since Plato's time. The concept implies, not that man *has* a soul, but that man *is* a soul—man is a mind that happens to be in a body. Man is a kind of pilot in a boat—the body being the boat. This philosophy implies dualism: the union of the soul with the body is merely accidental and constitutes a permanent danger to man.

According to this view, man's real world is not the material universe—the world in which we live today; rather, it is somewhere else: a spiritual world beyond this one; and the two worlds are in opposition. This leads to a pessimistic view of human life on earth; it implies that matter, material things—alcohol included—are all evil. If it is accidental for us to be here in this world, then material things are things we have to be careful of and put aside as much as possible.

The contrasting view is what I would call an exaggeration in the other direction: man is purely and exclusively a material being—more complex and involved, to be sure: in the process of evolution, we start from the most inferior being and go through the animals until we finally reach man; maybe later on we will have Superman, and finally—who knows?—Batman? In any case, man is only a material being, and the earth with its material goods is the only world of man. This view implies the denial of spiritual and moral values, of human freedom, and generally leads to a hedonistic view of human life. *Carpe diem*, the Roman poet Horace wrote;² *carpe diem, quam minimum*

credula postero: catch hold of today, and put little trust in tomorrow.

There are also contrasting views of society: the individualistic concept and the totalitarian one. Individualism views man as the god of the universe; in this philosophy, society is devalued; if society has any value at all, it is merely as the servant of the individual. This also implies the egoism of each and every individual and leads to what Hobbes has said, *homo homine lupus*: man is a wolf to his fellow man—because, after all, if I have to strive only for my own interests I am the enemy of the other fellow. On the other hand we have the totalitarian view of society, according to which the individual is only the servant of society—only the tool of its purposes, which may be military or racial or anything; individual rights and values are denied.

An integrating view

I would like to present what I consider an integrating view of man and society: the personalist view, which, in the first place, states that the human person is essentially both spiritual and material, in the unity of his nature: not a mind *in* a body, but a being composed of mind *and* body. I cannot say that I am merely a thinking being: my hand is part of myself—when I burn it, I know so. Both mind and body constitute the richness of my being and must contribute to its progress.

Here I would like to suggest some metaphysical considerations: I won't insist on them, but if man is both body and mind, matter and spirit, then I think this implies that he is a created being. We have no laboratory in which to fashion the spiritual man; there is necessarily a Creator at the origin of things, who gives life to man. For man to be, then, means that he has been *given* life; and to be given something means to be loved. Thus, for man to be means essentially that he is loved. If one is loved one must love also; this is why human life is essentially based on interpersonal relations involving love.

In the second place, the human person is endowed with the privilege of freedom, and therefore is a *moral* being. Now when

e say that man has freedom, it implies that, to a certain extent, he is a self-making being: he is not only the result of the determinisms of nature; but, by his free choice, he is partly making himself. He has to fashion his own personality, assuming the different determinisms of his material condition; he has to build intellectual, artistic, technical and moral habits or skills.

Two kinds of freedom

This freedom is not absolute, it is conditioned by various factors. And it is not an end in itself. It is a means, a tool, with which to reach perfection. Philosophers distinguish two kinds of freedom; they speak of the freedom of choice, by which we choose a means towards an end, and the freedom of perfection—the freedom that is found in achievement.

For example, freedom of perfection means that the skilled pianist is freer than I am when he sits down at the piano—he can do more with a piano. I don't know how to play the piano; my wife could play you a nice sonata or something, but I am only a listener. Now when you choose, freely, to acquire a skill, you relinquish some of your freedom of choice; that is the only way. If I want to play you something on the piano, but don't want to be bothered taking lessons and practising because I don't want to lose my freedom of choice, what kind of sonata will I play? Everyone will leave, very quickly.

Freedom and self-expression

If I say that I want to keep my freedom of choice and so I don't want to acquire any skills, you will think I am crazy—and you will be right. Freedom of choice exists so that I can make choices for my development; and when I develop myself by acquiring a skill, I have freedom of perfection in that regard. Is the pianist as free in his choice once he has committed himself to taking lessons and practising? No; he has not that freedom of choice found in the unskilled person—but he is a much better pianist. He is freer, in that sense, because he can express himself better. And that is the reason for skills, or what in the

study of ethics and morals we call virtues; virtues are simply moral skills—good moral habits—habitual dispositions whose function is to enable man to express himself more perfectly.

Freedom implies responsibility

As a corollary, then, if we have freedom we have responsibility, for we can make good or bad use of our freedom: we can use it to acquire either the good habits we call virtues or the bad habits we call vices. It is too bad that at times we consider virtues as if they were lifeless objects, as if they were not a means of *épanouissement*, as we say in French: of personal achievement, a perfecting of the being. When we speak of a smiling virtue, we shouldn't need to say "smiling;" simply to say "virtue" should imply smiling, and happiness and joy. A virtue is a means of achieving oneself, of developing oneself while, on the contrary, a vice does not favour the full development of the personality: it diminishes it.

In the third place, human personality can attain its perfection only in and by means of society. The human person is essentially a social being—a being of communion. This social character of man is rooted both in human needs and in human richness. Psychoanalysis has shown us the importance of interpersonal relations for the development of the person; and the richness of the person can receive its fulfilment only in interpersonal relations with others. Thus man, in the personalist view, is not the servant of society; and society is not merely the servant of this or that particular individual, but of the common good—the good of each and every human person.

Solidarity essential

This implies human solidarity: we all depend on each other for our development. Had it not been for certain workers, would we be here today, listening to philosophy? If we had to make our clothes ourselves, and prepare our own meals, could we spend two weeks thinking about others? It would be a physical impossibility. Society, then, is necessary for the development of

the human person; and social solidarity is necessary for the development of each person and for the progress of all persons—of society itself.

But social solidarity implies social responsibility. Every man has the duty to let his fellow men benefit from the richness he has received from society: one has not only to receive, one has to give; that is the basic condition of a sound democratic society. And with social life as complex as it is nowadays, there is a need of personalization in society—of extending responsibilities, so that there are more and more responsible people. There is a need for what we call intermediary groups, which are very important for the extension of responsibilities. I will come back to this point later.

I have suggested that virtues are not dead things, not static elements by which we are contented and satisfied, and which let us sit down and say, "I'm happy." On the contrary: they are dynamic elements in life—dynamisms for the perfecting of man. This leads us to the second part of this discussion.

I. A Dynamic Concept of Sobriety

What is sobriety? The usual term is temperance, but there is an ambiguity in this word: even today, when some people speak of temperance they mean total abstinence. The two are not the same thing, and sobriety is not the same thing as temperance—it is just one part of it.

What, then, is sobriety? It is a virtue. And what is a virtue? It is a quality acquired by the human person, a habitual disposition added to his natural powers, making their exercise easier and more perfect. I am not too good at golf, but I have the natural physical capacity, the natural power, to play it; if I practise and practise, I will acquire skill and become a better golfer. Similarly, we have the natural power of drinking—we don't acquire it—but we can drink in different ways; and sobriety is the virtue that is added to our natural appetite of drinking.

Virtues are skills of the personality; they help one to be a

better person. They are agents of enrichment, of maturation. Maturity implies development in equilibrium, and this equilibrium is part of virtue. Virtues are expressions of human freedom—that is, of the second type of freedom I mentioned, the freedom of perfection; they are rooted in our freedom of choice; they are, therefore, agents of progress.

Vices diminish freedom

As I said earlier, vices, on the other hand, diminish human freedom and perfection. They are agents of decay, disorder and slavery. A man may choose freely to be an addict, but once he is an addict he no longer masters at least one of his appetites; but if a man is the master of his own appetite of drinking, he is a free man in that respect.

There are different kinds of virtues: the theological virtues: faith, hope and charity; the intellectual virtues: science and art; and the moral virtues: prudence, temperance, justice and fortitude. Sobriety is one of the moral virtues, and is part of the virtue of temperance. Temperance controls all the appetites according to reason and prudence; but sobriety controls the drinking appetite in particular. Sobriety then, is a habitual disposition that controls the drinking appetite according to reason and prudence.

The normal satisfaction of appetites is accompanied by pleasure, and I think all the pleasures we have in life are nothing but a very limited participation in the joy and happiness of God. As I said earlier, to be created is to be loved. Everything that is created is good; and when God creates out of love, suppose he is happy in creating. Therefore we are not to look at pleasures as if they came from the Devil: they are part of the goodness of things, and to appreciate them is to appreciate their Creator. If somebody gives you something, you don't say to him: "You are very kind, but I don't like what you have given me." If we love God, we should love what he has given us in his goodness.

Although the pleasure we take in the normal satisfaction of

ur appetites is a participation in the joy of God, we are complex beings composed of both mind and body, and this satisfaction can at times result in a certain disequilibrium—we can forget the order of things. If the satisfaction of our appetites is to enrich us rather than enslave us, it has to be regulated by right reason. That is why there is need of a special virtue to regulate our appetites—to fortify us in the use of material things so that their use becomes an agent of equilibrium and progress, not of disorder. That is why we need the virtue of temperance; specifically, that is why we need the virtue of sobriety to regulate our drinking appetite.

Two forms of sobriety

There are two valid forms of the virtue of sobriety: moderation and abstinence. If moderation cannot be practised, then abstinence must be observed. And, in my philosophy at least, if the virtue of sobriety essentially implies the mastery of one's drinking appetite in relation to alcoholic beverages, it is irrelevant whether one makes use of that appetite or not; what is essential, whether a man drinks or abstains, is that he act like a human being.

Both moderation and abstinence, then, can be virtuous, but in both instances we have to be very careful not to identify a natural tendency with acquired virtue; they are not quite the same thing. You cannot be virtuous if you do not either abstain or drink moderately, but you can do either without being virtuous. I can abstain from drinking just because I want to show that I am somebody; that is not virtue, it is an exaggerated pride. I can even drink moderately—just take one single drink—because I want to show, as an adolescent, that I am a man. That is not the virtue of sobriety; it can be virtuous, but it can also be something else. The virtue of sobriety is an acquired habit or skill, added to the natural appetite of drinking, making you the master of that appetite according to the norm of right reason.

The moderate use of alcoholic beverages has to be qualified:

alcoholic beverages are material goods that have definite properties; they are not necessary to life. One has to drink something, but one is not obliged to drink alcohol; one can drink something else.

Have something for the non-drinker

This is something we have to remember, especially when we offer drinks to people. We like to say that we live in a pluralist society, but we are not pluralists when we offer only alcoholic beverages. Many people can have various good reasons for abstaining from alcohol. If you are the host, surely you want to please all your guests; but you are not being courteous to these people if you offer them something that does not please them because, whether they are ill, or are taking medicine that goes badly with alcohol, or are alcoholics, or for some other reason, they don't want to drink it.

As I said, alcoholic beverages are not necessary for life. At the same time, if taken with moderation, they can contribute to a certain betterment of it. Some drinks have digestive value; all can remove a certain sadness of mind—the Psalmist says³ that wine “maketh glad the heart of man”—they can favour friendship, and so on. But they also have certain properties that imply a qualified risk for the user, and we must also consider this aspect. Therefore, the moderate use of alcoholic beverages, like any other human act, is virtuous if done with reason and prudence; any human act has to be made according to reason and prudence; otherwise, it becomes an inferior type of act, not fully human.

Abstinence must be positive

Total abstinence from alcoholic beverages should not be from a motive of disgust; that would not be virtuous. Dislike is a negative reaction, and virtue is never negative; moral life is always oriented towards positive aims and goals. Therefore, even abstinence has to be regulated. Abstinence, regulated by reason and prudence, is a virtue if it is for the sake of something

positive: physical and moral equilibrium, friendship, social service, or for the sake of the love of God; but there must be positive reasons.

In any case, in whichever way you want to practise sobriety—in the form of moderation or in the form of abstinence—sobriety itself is necessary, as are all the moral virtues, for anyone who wishes to be mature—who wishes to be a real adult.

III. The Individual's Responsibility

The third part of this discussion concerns the responsibility of the individual towards himself in the practice of sobriety, and toward society in relation to the problem of alcoholism. First, then, very briefly, some general rules about sobriety in the individual.

1. Every man, as a human being, must practise sobriety—either by a truly virtuous moderation, or by total abstinence; otherwise, he is not an adult.

2. When, for any reason—there can be many—the moderate use of alcohol is practically impossible, total abstinence becomes the necessary way of practising sobriety.

You have two ways; if you cannot practise it one way, you must take the other—you have no other choice. What else can you do, except cease to be an adult human being? Everyone must be temperate; but for some people, for definite reasons, it may be essential to be abstinent. Our freedom, I have said, is conditioned, not absolute; and if, in order to reach my perfection, I choose to abstain from something that is not necessary to life, what is wrong with that?

3. Particular categories of persons for whom alcoholic beverages constitute a special risk are firmly recommended to abstain, at least for a certain time.

Let us suppose I am a specialist in surgery, and I have to perform an operation on someone: will I take two or three drinks before going in to perform the operation? If I do, I am taking a serious risk. Young people in the period of their growth might

be advised to abstain. Persons holding certain important offices while in the exercise of their duties, might be advised to abstain. "It is not for kings to drink wine," says the Book of Proverbs, "nor for princes strong drink: lest they drink, and forget the law and pervert the judgment of any of the afflicted."

4. Certain persons may freely choose joyful total abstinence for moral, social and religious reasons. I say joyful, because it is sad to see sad abstainers—but it is so stimulating to see happy ones! And there are many people who abstain, not because they don't like liquor, not because they dislike those who drink, but because they believe abstinence can have meaning in their life. Abstinence, as I said earlier, must have a positive meaning; otherwise it means nothing.

Two reasons for abstinence

To set a good example might be one reason for abstinence charity and help towards the alcoholic might be another. Paul Perrin, the French doctor who specialized in alcoholism, wrote that it might be very advisable for those who deal with alcoholics to abstain, at least for the time that they are dealing with them. It would create a similitude, a reciprocity in action between the therapist and the alcoholic, which would favour positive action.

The last and, I think, the most important part of this discussion has to do with our responsibility as citizens. It is not enough merely to practise sobriety. Human solidarity implies social responsibility; we have seen that social life is essential to us and therefore we must take some responsibility for the sobriety of the people around us and in the world. It is not a question of saying, "If he is not sober, it is my fault;" that is not the point. We live in society—we have been married to society for better or for worse. We have not only to share the good things of society; we must also contribute to its betterment as, most probably, we contribute to its imperfections. Therefore we should all take part in trying to solve the endless problems and difficulties of society.

This great problem of drunkenness and alcoholism has biological, psychological and social factors, but it is also a problem of human responsibility, both social and personal. The person who becomes a alcoholic has some responsibility to society and to himself for his condition. At times we forget that; he forgets it too, and there are times when he cannot bear to think about it. There is always some freedom in the initial steps a person takes towards alcoholism, no matter to what extent this freedom is lost later on; in a sense, the alcoholic, as he becomes addicted, voluntarily surrenders his freedom. His greatest need is to recover his freedom—to acquire the will to be cured of his condition. He needs help to think about his own responsibility. He needs to have a person near him who will love him.

On the other hand, we as members of society have a responsibility to diminish the social factors—inequalities, stresses, lack of adjustment—that contribute towards the development of alcoholism in the individual. We also have to assume more specific and immediate responsibilities towards alcoholism. We should do this through positive aims—not through “anti” campaigns; and one of these positive aims, possibly the most basic and most important, should be to create a climate of sobriety in the community.

Adult image implies liquor

Is sobriety considered a sign of adulthood in the society we live in? It seems at times, especially to young people, that you have to take a little drink, and maybe a little more than you should, just to show you are grown up. Our social conditioning is such that the image the young have of an adult implies liquor, and, at times, a little too much liquor. We must try to remove this and other myths about alcohol by correct publicity based on facts, based on the joy of sobriety in either form. A positive education through popular courses on alcoholism and sobriety is highly desirable, in this respect.

Everyone should also try to help in the rehabilitation of alcoholics, and this should involve a more intensive collaboration

between public agencies and private organizations—between the specializing agencies and the popular temperance groups. I know that such collaboration already exists, but I suggest that it could be more effective. This is true community treatment, and I believe it is very important in the rehabilitation of alcoholics.

Involve more people

The last positive element I would like to mention is the distribution of responsibilities. We need responsible citizens; let us form them by giving them responsibilities. I spoke earlier of intermediary groups, intermediate bodies; these are associations of any kind in which responsibility is distributed rather than being concentrated in the hands of one or two persons. These are more truly democratic, because they involve more people.

Our society is too passive, too receptive, not active enough. We are beings of communion. L'Association Lacordaire du Canada, of which I am a member, was founded by an alcoholic. He quit drinking, and then didn't know what to do with his time. His spiritual adviser said to him, "There is only one thing to do: go see other alcoholics, and tell them how happy you are." And now in Canada there are about one hundred thousand members who are happy about it. And there are also other movements, doing marvellous things. Alcoholics Anonymous knows all about this—making the alcoholic responsible for others as well as for himself. We are beings of communion. Often we think too much about our own trite difficulties; if we look at the troubles of others for a while, and try to act positively on them, we often find later that our own problem is no longer there.

I spoke earlier about an integrating philosophy—an integrating view of man. I think it is the same in the practical field. Human problems are complex and require a multi-dimensional or interdisciplinary approach—all disciplines working together. As Dr. Karl Stern writes,⁶ we have had enough of these philosophies of reduction, which oversimplify problems and make all ques-

ions one-dimensional. Human life is too rich to be viewed under one aspect only. All these aspects are complementary: the medical, the psychological, the moral, the philosophical, and the rest.

The religious aspect is not to be neglected: we know that religion is very significant in social behaviour. I mention the Christian religion here, because it is the one I know, the one I try to live up to. According to Christianity, all our fellow men are our brothers—the alcoholics included. And who despises a brother? If all Christians would live up to the Bible and look on their fellow men as brothers, if the alcoholic could find a brother in every Christian in the country—a brother who loves him and gives him significance in life—I think half the problem would be solved. Bishop Fulton Sheen writes⁷ that “Alcoholism cannot be driven out; it has to be crowded out.” Crowded out, I might add, with your help and the help of each and every citizen.

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To Drink or Not to Drink: The Over-Drinker's Responsibility

by Melville Gooderham, M.D.

I do not consider abstinence, in itself, to be either the ultimate goal of alcoholism therapy or a satisfactory criterion of successful therapy. I believe that the proper concern of the therapist is not with drinking in itself, but with drinking that causes damage. It does not matter whether a person drinks or not, provided that, if he does drink, his drinking causes no damage to himself or to others around him. If no damage ever resulted from anybody's excessive use of alcohol, there would be no justification for concern about anybody's drinking, or for the existence of alcoholism clinics.

The measure of success

Success in alcoholism therapy, in my view, should not be measured by the degree of abstinence achieved, but by the degree of reduction in the damage caused by drinking, and by the degree of ability shown in coping responsibly with the problems of living.

The misuse of alcohol is only part of the total behaviour pattern of any given over-drinker. Examination of his total behaviour pattern will always reveal areas of irresponsible behaviour other than that pertaining to his use of alcohol. In considering the over-drinker's total behaviour pattern, alcohol appears to be one of the instruments he uses to assist his denial of reality. The proper goal of therapy, then, is to help the over-drinker to stop using alcohol in this way—to teach him to change his use of alcohol, so that he will then be able to develop more responsible methods of behaviour.

The commonly presented arguments for insistence on abstinence are as follows:

1. *No true alcoholic can ever drink again. If a patient does*

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return to moderate drinking, he was not an alcoholic in the first place.

In the first place, there is no such thing as a "true alcoholic." To use this phrase is to deny what is now generally accepted, that alcoholism shows itself in different ways in different social groups, in different individuals, and even at different times in the same person.

In therapy at the East Toronto clinic, we find it useful to challenge the "loss of control" concept: we suggest to the patient that it simply offers him an excuse to avoid responsibility for his excessive drinking. We believe that each of our patients can recall at least one occasion when he drank but did not, at that time, get drunk; thus, we do not believe that one drink demands that every over-drinker gets drunk—although we do believe that alcohol can serve as the stimulus to activate the habit of over-drinking, so that it may be very difficult not to get drunk.

Binges are planned

Regardless of the effects of alcohol on the body, alcohol does not *make* anybody do anything. What it does is free the drinker of his controls; it facilitates his denial of reality and his escape into fantasy. We believe that every over-drinker knows why he drinks too much, although he may not be aware of the reasons when he first enters therapy. We try to show the patient that his drinking episodes are planned, that the perpetuation of his excessive drinking behaviour is partly planned, and that his familiar retrospective comment, "I only meant to have two drinks," is pure self-deception.

2. The sure way to avoid damaging drinking is not to drink at all.

This is true; but it is just as rational and scientific as saying that the best way to avoid automobile accidents is to stay out of automobiles. At least ninety per cent of the people who drink alcohol do not suffer from alcoholism.

3. There is no way of determining, at the outset of treatment,

which patient can or cannot safely experiment with moderate or "controlled" drinking.

This is quite true; we believe that both abstinence and moderate drinking should be prescription items, based on knowledge of the specific situation. In practice, we generally recommend abstinence, at least for a period of thirty days, for reasons that will appear in the following pages.

4. *Lastly, it can be demonstrated that a great number of patients do not want to drink moderately. They would like "to be able to drink like other people," but they say, "One or two drinks does nothing for me," or "I wouldn't thank you for one or two drinks."*

This simply means that if some patients may not drink to excess, they do not want to drink at all. Of course, abstinence is the necessary consequence of this position.

An instrument of therapy

It follows, then, that it may very well be necessary for certain patients to remain abstinent. If they make this decision, they should be supported in it. But it does not follow that *every* patient has to become abstinent. In this context, abstinence is an instrument of therapy, not a goal.

Drinking changes the way in which an individual communicates with himself and his environment; it also changes the way in which the persons in his environment communicate with the drinker. This is true for all who drink, regardless of how much they drink. The result of this is that not all the effects of consuming alcohol are harmful, and some of them, in many instances, are even advantageous to the drinker.

To many people, the world is dull and uninteresting without the use of alcohol. Many overdrinkers are intraverted, shy, malfunctioning individuals. When people like this consume enough alcohol to change their state, although not enough to cause inebriation, the world for them becomes bright, joyful, worth living in. They become outgoing, happy, pleasurable people. Many of our patients have achieved a great deal of

economic success, even while they were drinking heavily. In fact, we find in certain patients a specific use of alcohol that enables them to sustain themselves successfully against the vicissitudes of life and to reach a considerable degree of seniority in their respective lines of endeavour—even though the once-reliable mechanism is now beginning to break down. It is difficult to convince a patient that his use of alcohol is wrong when he can look back and count a great deal of success to his credit while he was supposedly drinking in an aberrant manner.

One must also consider the case in which the drinker has used alcohol efficiently to help him tolerate undue stress: for example, a spouse who does not drink, or who drinks very occasionally, and who is emotionally severely disturbed. In such a case, the psychopathology is really in the spouse; however, because of the moral implications of drinking in our society, the drinker can be labelled an “alcoholic”—particularly where economic stress results from his use of alcohol. What he is actually doing is medicating himself with a type of tranquillizer; the alternative might well be far more serious: desertion, assault, or even murder.

Meaning of “slips”

Recurrence of excessive drinking after an apparent cure is often interpreted as a regression to or a recurrence of the old illness. It can just as validly be interpreted as a regression to the use of old habit patterns to deal with stresses resulting from new situations; this is not the same thing at all.

The focus on abstinence as the goal of therapy for all patients, and as an indication of success in therapy, does not take these factors into consideration:

- the potential ability of a patient to fulfil certain basic emotional needs responsibly;
- changing circumstances of the environment, which present new difficulties in fulfilling these needs;
- the fact that certain patients have not remained abstinent, but are still fulfilling their needs in a responsible way;

—the damaging behaviour that becomes more apparent consequent to abstinence in certain patients;

—the use of “drinking” or “not drinking” as an instrument for manipulating the environment in an irresponsible way;

—the fact that insisting on abstinence, instead of sobriety as a *sine qua non* of therapy may well prevent patients in the early stages of alcoholism from coming for help at this time; and

—the symbolic meaning of abstinence to the patient, which would like to go into in greater detail.

Symbolism of abstinence

Over a period of time the alcoholic has developed a pattern of alcohol use that is intimately interwoven with all aspects of his existence. He has come to rely on alcohol to fulfil many of his needs. The sudden removal of alcohol, without any other changes, is for him a deprivation comparable to the removal of driving privileges for the average Torontonians. It is a real loss to the alcoholic, and must be appreciated as such. However, we have come to realize that there is something of equal significance in the symbolic meaning of abstinence, and I am not at all sure that some of the greatest resistance to progress may not lie in this area.

By questioning patients I have been able to ascertain three symbolic interpretations of abstinence, and there are undoubtedly more:

—self-classification of the abstainer with the rigid, anti-fundamentalist, holier-than-thou “prohibitionists,” and a removal from the fun-loving good-fellowship of the benevolent company of drinkers;

—submission to the control of another person, generally the marriage partner; and

—in men, the implication that not being able to drink means that one is not a whole man; abstinence, then, is a form of castration.

It is essential to appreciate that, both symbolically and in other ways, abstinence means an added burden to an already

disturbed patient, and hence abstinence can in itself be dangerous.

Nevertheless, there is a good therapeutic basis for encouraging abstinence; indeed, a period of abstinence is generally essential to develop a constructive pattern of growth in the patient's personality.

Abstinence is essential to constructive therapy, not only as long as the patient still shows evidence of physical dependence on alcohol, but also as long as he is *psychically* dependent on alcohol: as long as he is still drinking in excess, and as long as he is still drinking in response to the same, similar, associated or related stimuli; these habit patterns must be extinguished or alternate patterns established.

Clearing the air

An additional reason for temporary abstinence, and possibly the most important, is that because of the popular moralistic attitude towards over-drinking—that "over-drinking is the cause of all the trouble"—and because of the fact that drinking is popularly equated with over-drinking, the drinker tends to become the whipping-boy of his group. The only way to clear the air and find out what is really going on in a relationship between an over-drinker and one or more other persons is to remove alcohol from the scene completely. Again, a minimum period of one month is essential.

On the other hand, I believe that some patients may be permitted to drink—if they can do so in such a way that they are always able to assume responsibility for their behaviour and to behave responsibly. Specific use of alcohol to conform to social pressures may also be permitted—provided that over-drinking is not required by the patient's social group: trying to conform to the drinking standards of an "in" group may be what established the patient's pattern of over-drinking in the first place. Within the group, over-drinking may not be considered aberrant behaviour; however, the group's drinking may be considered aberrant by society at large, and the consequences of over-drinking may be considered aberrant behaviour both

by society and by the group. If over-drinking in this way is the only reason for drinking, then abstinence is a must—unless the patient is prepared to leave that group and join one in which over-drinking is not a condition of acceptance.

Abstinence, however, should not be used as a determinant of continued attendance in therapy. Rather, the patient's failure to be able to remain abstinent should be used as a topic for exploration. The therapist can determine what factors are exerting such a powerful influence on the patient that he does not appear to be able to behave in any other way. An additional reward for the alert therapist is that he can better determine the present rewards that the patient is obtaining from drinking.

R_y: abstinence or moderate drinking

From the therapist's point of view, it is extremely valuable to ascertain whether the drinker can or cannot abstain. This knowledge will help the therapist to determine which components of the patient's drinking pattern are most active at that time and thus help him to evaluate whether moderate drinking should be prescribed for a trial period, and when. The resumption of drinking of any sort should be considered in the context of the treatment program. It should be discussed with the therapist before it takes place, and further abstinence should only be encouraged if the therapist can provide practical reasons. Theoretical reasons, in the popular sense, will be of no avail with the drinker.

It must be clarified that I do not think it is sensible to attempt any on-going therapy with a patient who is continually drunk. The patient fully understands that drunkenness distorts his relationship with others and his ability to function completely; in fact, these are two of the reasons why he uses alcohol. Therefore, if he is interested in entering into a therapeutic relationship, he will accept the suggestion that a short-term period of abstinence is indicated as a practical measure.

I believe that there is a place for rules in any therapeutic endeavour. However, I also adhere to the belief that it is futile

to insist on a rule that one cannot enforce. I know of no way of making any patient remain abstinent simply because I, the therapist, say he must. If a patient could remain abstinent solely because of the order of the therapist, no further therapy would be needed, and we could cure over-drinkers on an assembly-line basis.

I believe it is impossible for a therapist to be anything other than an authority figure to a patient, no matter how relaxed this relationship may be. A father is always a father to his son, but it is possible for a father to treat his son as another adult and not as a child, and to communicate with him on an adult level. I believe that a similar relationship should be developed between therapist and patient.

Alcoholic people have always had trouble in relating comfortably with authority, and alcoholic patients generally attempt to maintain a "parent-child" relationship with the therapist, manifested either by rebellion against his authority or by an adoring worship in which they will do everything they can to please this new-found loving, protective parent. In addition, alcoholic patients are extremely sensitive to moods, atmosphere and feelings, and can generally read the therapist like a book. If they perceive that it is important to the therapist's value system that they remain abstinent, they can put one over on him any time they like.

"Games drinkers play"

All therapists are acquainted with the use of alcohol as a means of defying authority, as a threatening weapon, as a means of hitting and disturbing and as a means of getting attention. We have all experienced involvement with the patient who creates a commotion by threatening to drink, who blows up a storm involving family, friends, therapist, and society in general; but we generally do not appreciate that we have been manipulated until after it is all over.

In the case of the patient who is "aiming to please," a drinking episode is interpreted by the patient, and sometimes by the thera-

pist, as "letting the therapist down." This only serves to increase the patient's load of guilt, his overall discomfort, and his need to drink again.

The ideal relationship is for the therapist to act as an experienced adult who permits another adult, the patient, to avail himself of this experience. In order to facilitate this relationship, it is imperative for the patient to make his own decisions in all matters. The therapist should point out the possible consequences of any decision, and indeed may well offer alternatives; but he must support the patient in his decisions until they prove to be in error, when there will be a review of the situation.

Alcoholic patients are notorious for not assuming responsibility and, along with that, for not making decisions. I believe that the most important decision for any patient to make is the one about his use of alcohol. If the therapist does not insist on abstinence, but does insist on "no drunkenness," the decision to drink or not to drink rests entirely with the patient; in my opinion, it is the first step that he must make in order to assume adult stature.

If the therapist insists that the patient has the privilege to drink or not to drink, as has any other man, but similarly that he has no right to abuse this privilege, the elements of castration are removed. If the patient decides to remain abstinent he does so on the basis of his own strength and reason and is not submitting to the control of any other person. He is now acting in a responsible manner.

Patient must decide

I want to emphasize that in not demanding abstinence the therapist is not insisting upon drinking. However, the fact is that many patients will interpret it in this way. This misinterpretation of communication is one of the ways in which our patients function badly; this, in itself, can be used therapeutically. The important element is that the patient must make the decision himself, and is then supported by the therapist in the decision.

Whether every patient who has once suffered from alcoholism

must remain abstinent for life is no longer really an argument; Davies* and others have demonstrated that this belief is not correct. However, the patients we see at the East Toronto clinic are so deeply involved with alcohol that they are almost beyond our help. The precept: "Anyone who suffers from alcoholism may never drink again" may actually be reinforcing this situation by keeping prospective "early" patients away.

If we were to change to the precept: "Certain types of over-drinkers should remain abstinent for life, but not necessarily all over-drinkers," we might open the door to a different type of patient. We might then be able to involve people in therapy who are still in the early stages of alcoholism, or who are not yet desperately ill with it.

*D. L. Davies, "Normal Drinking in Recovered Alcoholics," *Quarterly Journal of Studies in Alcohol*, 23, 1 (March, 1962) 94-104. Dr. Davies, Dean of the Institute of Psychiatry at the Maudsley Hospital, London, England, reported in this paper that seven out of ninety-three alcohol addicts were found on follow-up to have been drinking socially for continuous periods of seven to eleven years after discharge from the Maudsley Hospital, where they had been treated for their addiction. None of them had been drunk in that time and all were socially better adjusted than they had been for a year before admission. Dr. Davies suggested that such cases are more common than has hitherto been recognized, and that the generally accepted view that no alcohol addict can ever drink normally again should be modified—although all patients should be advised to aim at total abstinence. Dr. Davies' paper attracted much thoughtful comment by other professionals in the field of alcoholism therapy: see especially *Q.J.S.A.* 24, 1 (March, 1963) 109-121; *Q.J.S.A.* 24, 2 (June, 1963) 321-332 (which includes a response by Dr. Davies); and *Q.J.S.A.* 24, 4 (December, 1963) 727-735.

Alcoholism and Responsibility: Some Thoughts for Churchmen

by Charles Aharan, Ph.D.

In the last twenty years, a marked change has taken place in our society's attitude towards the alcoholic, and in the number of facilities that have been made available to help him with his difficulties. The promotion and gradual acceptance of the concept that alcoholism is a disease has been extremely effective in procuring a more humane and enlightened consideration for the alcoholic. However, the time is fast approaching, or already come, when we must question the usefulness of this concept. I do not believe that alcoholism is a disease, at least not in the traditional sense of this term. I suggest that alcoholism is a way of being—or, if you prefer it, a behaviour syndrome. Its major and identifying feature is an ever-increasing reliance on the effects of drinking alcohol as a means of adapting to the conditions of one's existence. It may express itself in a variety of ways, depending on the interaction of certain characteristics of the individual and his culture. There is no question that the alcoholic is frequently a very sick person, but his sickness is not the disease alcoholism.

Disease concept harmful

Many may argue that if the disease concept has resulted in so much benefit to the alcoholic, to question its validity is a useless academic exercise. This is not so. Unquestioning acceptance of the disease concept becomes harmful as a growing number of public and private institutions come into being to treat the alcoholic. Treatment programs narrowly based on the medical model, useful in the treatment of physical diseases, are

Dr. Aharan is Director of the Lake Erie Region of this Foundation. This article is adapted from part of a talk he gave in Toronto last November to a conference of church workers in the field of alcoholism and addiction, organized by the Anglican and United Churches. Much of the earlier portion of Dr. Aharan's talk, not reproduced here, appeared in his article, "Theories of Causation," in the Spring, 1966, issue of *Addictions*.

not merely wasteful but often downright harmful when applied to the management of alcoholism.

This is well illustrated when medication is prescribed for the alcoholic in a manner dictated by traditional practices based on the usual concept of disease. Consider the fact that by far the most widely prescribed medicine in the treatment of the alcoholic—the tranquillizer—is aimed at alleviating his discomfort and has little or nothing at all to do with curing his disorder. The alcoholic is, almost by definition, a person who has dedicated himself to the avoidance of discomfort through reliance on the effects of a chemical. When the alcoholic receives medication over a long period of time, the treatment service is communicating to him its agreement with his philosophy that discomfort is not to be endured, and is disagreeing only in the choice of the chemical used. In this sense, the prolonged prescribing of medication reinforces what I believe is part of the alcoholic's basic pathology—his notion that he should not suffer and that he is helpless—to say nothing of the real danger of switching his dependence to an even more damaging chemical than alcohol.

Reinforces irresponsibility

The chief danger in the uncritical acceptance of the disease concept is the tendency to consider that the sick person is not responsible for his condition. Admittedly it is this very tendency that has made application of the disease concept to alcoholism so useful in gaining more humane consideration for the alcoholic, but it is a sad commentary on our society that we seem to have to find some way of excusing the behaviour of troubled people before we are willing to offer them a helping hand. To excuse the alcoholic for his conduct is a potentially harmful practice, for it reinforces his already well-developed tendency to rationalize his conduct and to avoid his responsibility. If I were pressed to use one word to describe the alcoholic's behaviour, I could think of no better word than "irresponsible." The alcoholic tries to avoid making choices; when he does make choices, he makes

them recklessly and on impulse, and refuses, wherever possible, to accept their consequences. Recovery for the alcoholic depends on his gaining control over his behaviour and becoming responsible. I believe that this suggests that our approach to the individual alcoholic must rest on the assumption that he can be a responsible person and that, in all probability, he is capable of a great deal more in the way of responsible conduct than he usually exercises. This means that programs designed to help the alcoholic must neither excuse him for his conduct nor stand between him and the fair and logical consequences of his behaviour.

Acknowledge moral aspect

I have heard many people argue that the major value of calling alcoholism a disease is that it removes it from the realm of morality and enables us to replace punishment with treatment. I personally believe that the moral aspect is a central issue in alcoholism, and that it cannot be ignored in any successful treatment program. I see no danger in recognizing this fact, particularly if we can also recognize that hostility towards and punishment of the morally troubled person is not only ineffective, but is in itself a morally questionable stance.

To avoid the moral issues in alcoholism is at best stupid and at worst cowardly. The most widely effective program yet devised in the treatment of the alcoholic is clearly an ethical and spiritual program: the A.A. program rests on the assumption that the suffering alcoholic can and must make a choice or commitment and stick to it for at least twenty-four hours. The unique value of the A.A. program is in the method developed to persuade the alcoholic to make his choice. The possibility of making and sticking to a decision in favour of a sensible way of life is communicated in *Alcoholics Anonymous* in a manner that results in a greater probability of acceptance, and it is reinforced by the presence of others who have been successful in making the same decision.

Another great danger in the uncritical acceptance of the

disease concept is that it enables large numbers of people to avoid their responsibility to the alcoholic. By calling alcoholism a disease, responsibility can be shifted entirely to the medical profession. I have often been asked by clergymen: "What is my role in helping the alcoholic?" If alcoholism really is, as I have suggested, a way of being in which a person uses alcohol as a means of adapting to the conditions of his existence, clergymen should not have to ask such a question. I believe the reason the question is so often asked is because of the uncritical acceptance of the disease concept, which automatically identifies the medical practitioner as the ultimate authority.

I believe that alcoholism in the individual is symptomatic of a serious underlying personality disorder, characterized by an inner emptiness and the absence of purpose and meaning in the individual's life—in short, a weak character. As a social problem, I believe, alcoholism is symptomatic of society's failure to inculcate values that challenge the individual and provide meaning to his existence. In the extent to which a society encourages its people to pursue meaningless goals—goals that fail the individual and leave him exposed to the horrifying awareness of a futile existence—to that extent the society encourages reliance on chemicals that either blot out the awareness of life's emptiness or provide a temporary and false sense of purpose. The extent to which such a state of affairs is true of a given society is the extent to which the institutions that are custodians of that society's moral purpose have failed or, even worse, have misled their people.

Whose fault is alcoholism?

If a nominally Christian society is plagued with a high incidence of alcoholism and other alcohol problems, where should it look for the explanation? To the alcoholics, to the society that breeds them, or to both? It is, of course, much easier to look to the alcoholic and find the fault entirely with him, and perhaps also with the evil substance he has run afoul of. If we look to society and find that the fault also lies there, and if it is a

Christian society, then we must face the fact that a society supposedly based on Christian ethics has to a large extent failed its citizens, or that there is a serious failure in the practice of Christian responsibility in that society.

Churchmen avoid responsibility?

Could it be that by directing attention solely towards the alcoholic, and by claiming that individual human weaknesses and alcohol are the sole cause of alcoholism—or by saying that alcoholism is a disease, which is nobody's fault—we are actually avoiding Christian responsibility? When the Christian conscience seems to express itself primarily in opposition to open Sundays, the number of liquor outlets in a given area, the prevalence of gambling, or the use of bad language on the CBC, and remains silent on the savagery of war, the dehumanization of the poor, racial injustice, the unethical use of political and economic power and many other matters vital to man's survival, I feel there is no hope for Christianity and very little hope for mankind. Why has the Christian conscience concerned itself so vocally with the symptoms of a sick society and paid so little heed to the basic causes of that sickness? In the realm of alcohol problems, Christians have been quick to condemn drunken behaviour but have been relatively silent about the soul-destroying conditions of which drunkenness is but one symptom.

To some churches any use of alcohol has been considered a sin, and in all churches irresponsible use of alcohol is considered sinful. The attitude of official Christianity towards the alcoholic is the same, therefore, as it is towards the sinner. Christianity has had a long history of hating sin and, unfortunately, almost as long a history of hating sinners. The hostile and rejecting attitude directed towards sinners has varied with the nature of the sin. Drinking, and excessive drinking in particular, has always been quite low on the scale of acceptance. Hence, Christianity's hostility towards and rejection of the irresponsible drinker has tended to be severe.

Generally speaking, the alcoholic himself tends to feel that

he is beyond the pale. Somehow his view of Christianity has been influenced by his extremely negative feelings about himself; or, perhaps, his early religious experience has contributed to the development of these negative feelings. In any case, he finds it difficult or impossible to believe that the forgiving love of Christ, or the brotherly love of Christians, is extended to him. Many times you will hear an alcoholic express bewilderment about what has happened to him, in the light of his early religious training. He will often say, "I came from a good Christian home;" but he feels that having turned his back on the God of his childhood, he is beyond redemption; he feels that he has separated himself from God and man and that there is no hope for him. This attitude makes one wonder how Christian his early experiences really were. Obviously, the real meaning of the parable of the Prodigal Son failed to penetrate very far into his religious consciousness.

Message of love rare

Unfortunately, in the course of his drinking history, his encounters with Christian institutions and Christian representatives may very well tend to reinforce this basic feeling of despair. Time and again he will encounter judgments, and predictions of his well-deserved damnation. Rarely will he encounter the message of love. If he degenerates to the bottom of our social ladder, he will be aware that some religious institutions, which offer him the bare essentials for continued existence, do not do so out of love, but as bait; he will discover that the modern Good Samaritans, unlike the Good Samaritan of the parable, may have a price tag on their charity. Sometimes the price is not very high: just being a member of a captive audience, listening to yet another condemning sermon. Sometimes the price is very high, requiring the surrender of whatever integrity the alcoholic has left.

Christian institutions have long upheld the belief that sin must be judged and punished, and have felt it their righteous duty to help God in the work of judging and punishing the sinner.

The long history of this attitude is remarkable when one considers that the unique message of Christianity is forgiving love. Surely separation from God is punishment enough. In our society in order to extend the hand of brotherly love to the unfortunate among us, we have found it necessary to find some excuse for their behaviour, or to demand that they repent and admit that their misfortune is the direct result of their stubborn refusal to be as we are. We have somehow confused forgiveness and excusing; and in order to forgive we have found it first necessary to excuse.

Basic attitude unchanged?

There is now a growing acceptance of the idea that the alcoholic is worthy of humane treatment and respect, and I believe that much good will come of this changing attitude. I still have a lingering concern, however, for I wonder if this new approach represents a truly fundamental change in basic attitude, or whether a new excuse has been found. I wonder to what extent the new approach is permitted because a universal pardon has been found in the disease concept of alcoholism.

There are two points, of crucial importance to Christian responsibility, that may be related to the acceptance of the disease concept. Firstly, by the uncritical acceptance of the disease concept, official Christianity can continue to ignore its responsibility for the social conditions that contribute to alcoholism and rest comfortably in the belief that the condition is due mainly to some physiological or biochemical condition of the individual, for which neither the alcoholic nor society can be held responsible.

Church's voice may fade

The second point is even more serious. If the disease concept is accepted because it is a convenient way around the moral issues, then we can expect an increasing number of human problems to be called diseases so that the victims of these disorders will be offered more human consideration. This will mean that

Christian responsibility and concern with vital human problems will become increasingly limited and obscure, and the Christian position will be less and less relevant to our times.

It seems to me that instead of trying to find a way of avoiding moral issues, Christians should seriously question their traditional approach to the morally troubled. In order for the powerful, therapeutic Christian message of forgiving love to be applied meaningfully to human problems, the judgmental, condemning and punitive attitude of official Christianity towards the morally troubled must be eliminated.

Christian responsibility toward the alcoholic, I believe, can only be expressed by the attitude of forgiving love. Forgiving does not mean excusing; but it must mean, among other things, not hating him for what he is. Loving does not mean a sentimental permissiveness, or an indulgence of his behaviour; it means, among other things, a continuing concern when he chooses to persist in a self-destructive approach to life. Above all, it does not mean that we will shelter him from experiences whose consequences may help him to make different choices. Christian responsibility demands that the individual alcoholic be approached with an attitude of love—not because he has a disease, but because he is our neighbour.

New Booklet for Parents

A new booklet, *Clues for Parents*, has been produced by this foundation and is available from the Education Division at the address on the inside front cover of this magazine. No charge to Ontario residents, twenty-five cents outside the province. Partial contents of the fifty-two-page booklet: How Alcohol and Other Drugs Can Lead to Harmful Dependence; Parents Seek Ways to Prevent Trouble; Instruction in the Secondary Schools about Alcohol and Drugs; "How Far Apart Are the Opinions of Teen-Agers and their Parents?"; "Let Us Listen to Youth;" and Questions and Answers, including twenty-five ways to say "No."

The Case Against the Drug Culture

by Henry Anderson, M.A., M.P.H.

I suppose I should say at the outset that I haven't been on an "trips"—other than those that come naturally. I am well aware that the tripsters will therefore write me off with the wheeze "If you haven't tried it, don't knock it." I am unimpressed with that argument. There are many things I have not tried, and feel perfectly justified in knocking, simply on the basis of being human and having certain basic human experiences and feelings. For example, there have been other kinds of hippies, at various times, in various places, who thought they found fulfillment in killing or torturing or being tortured. I am quite prepared to abjure Sade's recommendations for consciousness-expansion without having tried them and with no intention of trying them. And I have no apology whatever to make for my lack of "empiricism;" for empiricism, like almost anything else, can become a vice.

Hippies reject false values

The proponents of LSD and marihuana and the like begin from a sound point of departure: they reject what they call the "false values" of our culture. So far, so good. Our society and culture have many false values, which should be rejected. The tripsters, for example, tend to be scornful of the "race for outer space;" and, in my judgment, quite properly so. But it is not enough to reject unsound values. The question is, what values are substituted—if any?

The tripsters substitute a "race for inner space." They use artifices to propel them, as astronauts use mechanical devices

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propel them into the other kind of space. I have no invariable barrel with the results the tripsters say they get. I am not a rim-lipped Puritan—at least, I flatter myself that I am not. I am not a foe of euphoria, transcendental and oceanic experiences, creativity, liberation from hang-ups, and some of the other things the true believers claim they get from their drugs. Far from it.

The problem is one of proportion. "Consciousness-expansion" is not *all* there is to living. I am in favour of many other things besides euphoria, and there are many situations in this life in which you cannot have everything: you have to make choices. This is one of those situations.

What about "middle space"?

The "race for inner space," as surely as the "race for outer space," evades the problems of "middle space," if I may coin a phrase. That is, problems located neither in heaven nor in Hell, but right here in the everyday, common-sense, real-life, experiential world. The bright young people in grey flannel suits who are turning their talents towards the computer technology of the aerospace industry, and the bright young people in grey flannel sandals who are turning inward to their private sessions, may think they have nothing in common; but in practical effect they are at one. If a very great many more bright young people don't turn their talents to solving the down-to-earth problems that are all around us, right here and now, there isn't going to be anybody's inner space left to explore; and outer space will still be there, but with nobody to explore it.

In June, 1966, in San Francisco, the University of California sponsored a big conference on LSD and the other hallucinogens. This conference seemed to me to miss the essential point; not one of the experts flown in from all over the country seemed even to hint at it. The big question with LSD, as with marihuana, peyote, mescaline, morning glory seeds, glue-sniffing, and all the similar devices, is not whether they are useful in treating alcoholism, whether they are addictive, whether they should be

legalized or outlawed, whether people under their influence occasionally run amuck, stab other people, commit suicide, and so forth. The big question is: are they a diversion, a distraction, a siphoning-off of energies desperately needed elsewhere, a way of opting out that is heartlessly unfair to those who are left? I submit that they are.

“Cast your burdens on Mr. Square.”

To be sure, if everybody in the world—all the Communists and other ideologues, all the hungry agricultural workers of this nation and every other nation, all the Negroes in ghettos in this nation and the Union of South Africa and everywhere else—if *everybody* were to renounce his economic and political and other grievances, and take the LSD route, then the problem I am speaking of would not exist. Personally, I doubt that I could bear to live in such a world, but it's a very hypothetical question; obviously, not everyone is going to agree to opt out. And should that, those who take the psychedelic way out are, in effect, adding that much more to the burden of those who choose to stay in “middle space” and fight its evils and try to make it livable and try to keep it going for the benefit of everybody.

What is needed is not more people blasted out of their minds. There are more than enough people out of their minds already. What is needed is more people *in* their minds—in their right minds. It is not really liberating, really humanizing, to have people hallucinating that everything is beautiful. Everything is *not* beautiful. What is needed is more people who can see what is really there: who know when a lake or a mountain or a forest is really beautiful, and who also know when it is threatened and are prepared to fight the lumber barons, the Division of Highways or whoever threatens it; and people who know that a dump or a ghetto is really ugly and are prepared to fight to change the ugliness.

Some law-enforcement officials may be under the impression that the young hippies and the young activists are one and the same group. There is some overlapping, to be sure; but not

nk, very much. By and large, the seekers after psychedelic experiences, although they may at one time have been involved in some kind of wrestling match with the real world, have left the arena.

This is not merely my opinion. Let me quote from a leaflet that was thrust on me the last time I visited the Berkeley campus. I was put out by a group of users who want to legalize marijuana by constitutional amendment.

Persons under the influence of marijuana are non-aggressive, amiable, easily pleased. . . . As a tranquilizer, it is superior to most of the products prescribed by doctors. . . . Users are too content, too happy, too unambitious to please the custodians of public morality.

These enthusiasts of pot are dead wrong on at least two scores. They are dead wrong in their grasp of what pleases the custodians of public morality. Nothing really pleases the keepers of our political-economic zoo more than contented, amiable, unambitious inmates. Nothing *displeases* them more than critics who say and do something constructive about their contents, rather than floating away on Cloud Nine.

Who needs contented cows?

Secondly, the potniks are dead wrong, or so it seems to me, in their version of the good life. They obviously believe that nirvana consists of placid people. I can imagine scarcely anything more terrifying. To pursue the pharmaceutical metaphor of the friends of marihuana, what this world needs is fewer tranquillizers and more energizers: more genuine aliveness and concern and passion, active support for the things that are good, and active indignation for the things that are not good.

You may have seen the story in the papers about Allen Ginsberg's recent appearance before a congressional committee. Last fall, by his own account, Ginsberg made a stab at becoming socially involved, but then he got high on LSD and ended up on a beach somewhere, on his knees, wrapped in fantasies about weed and a newfound love for Lyndon Johnson. Ginsberg and his friends think this is the latest religion. I think it is the

latest opium of the people, in a more literal and potentially more dangerous sense than anything envisaged by Karl Marx.

If the tripsters were frankly groping, stumbling, searching, seeking, growing, and eventually finding some way back to this world—in short, if they were genuinely open—I would feel differently. But I'm sorry to say I do not see openness and authentic searching. I see a great deal of smugness. The average tripster seems quite satisfied that he has the answers; that he knows the secret of it all; that he, unlike poor squares like me, is sailing new, rich, exciting, radical, uncharted seas of experience.

Escapism not radical

There is little ground for this self-satisfaction. In fact, what the tripsters are doing is very old and not radical at all. It has been tried in many societies, in many times, in many places and in many ways. Any good anthropology textbook mentions plenty of cultures that have institutionalized essentially what the tripsters are now asking: an escape from the dullnesses of ordinary existence, through visions, ecstasies, "mystical" experiences induced by drugs, driving rhythms, lights, dancing—precisely the same techniques used in "trip festivals" today. Sometimes the right to escape has been reserved to some priestly class. Sometimes it has been conferred upon everyone at intervals—the beginning of spring, the completion of the harvest, and the like.

I am not aware of a scintilla of evidence that these devices have made any difference in the productivity or happiness or creativity of those cultures, or in their survival. I see no reason to believe that these same old devices can play any useful part in helping our culture survive the atomic age.

The tripsters may say to me, "You can't put us down that way. We don't think your culture *deserves* to survive." Perhaps now we are getting down to the nitty-gritty—the gulf between assumptions that indeed divides us. I believe that people "dropped out," as Leary puts it, to a culture of fantasies, the drug culture, for negative rather than positive reasons: not so much because

They truly find their fantasies fulfilling, as because they are totally alienated—or, rather, like to think they are totally alienated—from any other culture that seems available. They do not see—or think they do not see, which comes to the same thing—any legacies worth preserving in Western civilization. I do see, or think I see, such legacies. It is the things that are worthwhile in our culture that enable us to perceive the things that are wrong.

Western civilization has been guilty of some of the greatest atrocities in the history of the human species; but it has also supplied a perspective of humanist values and ideals that makes possible for most of us to recognize those atrocities for what they were and are. They would have been taken for granted, viewed as fitting and proper, by most cultures of the past and many of the present. To illustrate: even the maddest of our warlords these days have to proclaim that they love peace. It has not often been this way before. During most of human history, peace has not been part of the *mores*. Warlords have openly revelled in their bloodthirstiness, and have been acclaimed for it.

Constructive rebellion

I am no apologist for our culture, to put it gently. But I know that there are many good things about Western civilization—including the concept of personal expansion and fulfilment and liberation, the very notion of the individual, which some of the tripsters seem to think they invented. They, and you, and I, ought to be grateful to our culture for providing us with these good, humanist perspectives. I want to retain them—to build on them. I believe that if they are properly employed they provide perhaps the best tools for constructive rebellion, the best framework man has yet developed within which to work on the things that are not good—all the cruelties, cloddishness, injustices and tyrannies. I do not think this is ethnocentrism; I think it is humanism.

I can assure the tripsters that if the H-bombs start flying they are not going to be selective in what they destroy and what they

spare. They will destroy baby and bath water—and soap and towels, too. I do not want the species to be set back ten thousand years and have to work its way up to the present point all over again. And, in case the tripsters are under any illusions about the nature of stone-age existence, it wouldn't be a bunch of happy savages sitting around in caves, eating peyote, at peace with themselves and the world, living off the fat of the land. People would be in thrall to despots, including those most ruthless despots, hunger and cold; and people would be clubbing each other's brains out in the competition for food and shelter; life would be "nasty, brutish, and short."

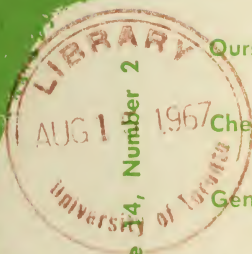
"Hang you, Jack, I'm turning on."

The very best that is in all of us is going to be none too much to keep that from happening. The odds, I fear, are not favourable. Everybody who says, "You knock yourself out if you want, man, I'm just going to take a far-out trip," everybody who picks up his talents and goes home, lengthens the odds by that much. If they were just playing fast and loose with their own lives, that would be one thing. But, in a real sense, they are playing fast and loose with my life, too, and yours. And I don't like it.

I might say, finally, that for bona-fide liberation, bona-fide radicalism, there is a vision that may be matched more than favourably against that of the tripsters. What is really fresh, really revolutionary—perhaps the only really radical idea left, the only authentically twentieth-century revolution—is the hypothesis that it is possible for a person to live a whole, rounded, aware, productive, creative, responsible, self-realized life, personal yet interpersonal, with peak periods and periods of rest, on the strength of his own powers, his own insight into his needs for fulfilment and what it takes to meet those needs, his own will and his own effort, without leaning on some Freudian or Marxian or other dogma, or computer programming, or any other kind of crutch—including drugs.

11.1. Addictions

SUMMER, 1967



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ADDICTIONS is published four times a year by the Addiction Research Foundation, an agency of the Province of Ontario.

The contents of each issue are selected on the basis of their potential interest to persons engaged in research, treatment or education in the field of alcoholism and drug addiction.

Articles published in ADDICTIONS do not necessarily reflect the view of the Foundation.

If you would like to receive ADDICTIONS regularly, or if you would like to know more about some aspects of the Foundation's work, you are invited to write to:

Addiction Research Foundation,
Education Division,
344 Bloor Street West,
Toronto 4,
Ontario.

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The Foundation has offices at:

Toronto (365-4521)—344 Bloor Street West
—221 Elizabeth Street

Toronto (East)—1468 Victoria Park Avenue (751-0955)

Fort William—1020 Victoria Avenue (622-1735)

Hamilton—143 James Street South (525-1250)

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Editor: Alasdair McCrimmon



Authorized as second class mail
by the Post Office Department, Ottawa
and for payment of postage in cash

A.I.T. Addictions

Volume 14, Number 2

Summer, 1967

Ours Is The Addicted Society

By Leslie H. Farber, M.D.

This has been called the Age of Anxiety. Considering the attention given the subject of psychology, theology, literature, and the pharmaceutical industry—not to mention the testimony from our own lives—we could fairly well conclude that there is more anxiety today, and, moreover, that there is definitely more anxiety *about* anxiety now, than there has been in previous epochs of history. Nevertheless, I would hesitate to characterize this as an Age of Anxiety, just as I would be loath to call this an Age of Affluence, Coronary Disease, Mental Health, Dieting, Conformity, or Sexual Freedom—my reason being that none of these labels, whatever fact or truth they may involve, goes to the heart of the matter.

Much as I dislike this game of labels, my preference would be to call this the Age of the Disordered Will. It takes only a glance to see a few of the myriad varieties of willing what cannot be willed that enslave us: we will to sleep, will to read fast, will to have simultaneous orgasm, will to be creative and spon-

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taneous, will to enjoy our old age, and, most urgently, will to will.

If anxiety is more prominent in our time, such anxiety is the product of our particular modern disability of will. To this disability, rather than to anxiety, I would attribute the ever increasing dependence on drugs affecting all levels of our society. While drugs do offer relief from anxiety, their more important task is to offer the illusion of healing the split between the will and its refractory object. The resulting feeling of wholeness may not be a responsible one, but at least within that wholeness—no matter how perverse the drugged state may appear to an outsider—there seems to be, briefly and subjectively, a responsible and vigorous will. This is the reason, I believe, why the addictive possibilities of our age are so enormous.

Addicted to addiction

Let me be more specific about the addictive consequence of this disability of will, which, in varying degree, affects us all. Increasingly, I believe, we are addicted to addiction. This is to say that, with few exceptions, we subscribe to the premise—whether implicit or explicit—that this life cannot be lived without drugs. And those who would repudiate this unpleasant premise by living without drugs are still more or less captive to it, in that so much of their consciousness must be given over to withstanding the chemical temptations that beset them. Withstanding is a lesser evil than yielding, but it is no escape from the issue of addiction, so that I would have to characterize the predicament as one of being addicted to not being addicted. I do not mean to suggest that we choose one course or the other but rather that both the premise and its negative variation exist in all of us. Even the most debilitated heroin addict retains his pride in the few items to which he has not become addicted.

Not many years ago—we had best remind ourselves—the problem of addiction seemed confined to a few chemicals: narcotics, alcohol and, perhaps, barbiturates, and it was then possible to make fairly clear distinctions between addiction and

habituation, based mainly on the presence or absence of physiological withdrawal symptoms. However, today even the well-publicized and allegedly extreme agonies of heroin withdrawal have been disputed by the Lazaruses who came back. Recently, a member of Synanon expressed to a reporter his disagreement with the fictional clichés that have acquired the status of scientific fact, remarking: "Kicking the habit is easy. It's not like that Frank Sinatra movie, crawling all over the walls. Sure, it's tough for a couple of days, but it's more like getting over a bad cold."

Fearing this view might be as extravagant in one direction as Nelson Algren's violent imaginings were in another, I checked with a friend who had been a staff member at Lexington. He thought the "bad cold" analogy an accurate one, and added: "We had far more trouble with withdrawal symptoms in barbiturate users."

Our appropriation of the drug user's vocabulary for our own purposes shows the extent to which the problem of addiction has invaded our daily existence. When our absorption with not only a chemical but a person, an activity, a distraction, an ideology seems to have more weight than is warranted, we say we are "hooked," meaning either that we wish we could be cured of our vice or else that we value the passion contained in our infatuation.

Turned on or off

If someone or something excites us pleasurably, we say he or it "turns us on," but if our response is indifference or boredom, we are "turned off." Our extension of these terms for our own purposes is, to some degree, a fashionable reaction to the notoriety drugs have earned in the mass media. However, my own belief is that we resort to the junkie vocabulary because it expresses a metaphysical or addictive shift in our existence that the older vocabulary did not quite account for—at least in ordinary usage.

Even if we try to restrict ourselves to drug-taking, statistics about the extent and degree of addiction are hard to come by,

Certainly we are no longer surprised to learn of the growing proportion of college students who resort to such drugs as marihuana, amphetamines, barbiturates, LSD, tranquillizers. One expert is quoted in *The New York Times* to the effect that about forty per cent of the students at the University of California use drugs from time to time. This figure falls somewhat short of Timothy Leary's immoderate proclamation: "Today, in the molecular age, the issue is not what books you read or which symbols you use, but which chemicals are part of your life and your growth."

Riot for pills

Numerical estimates notwithstanding, on the theory that convicts tend to riot for those privileges society deems essential, such as humane treatment, recreation, adequate food, civil rights, I am more persuaded by this news release:

WALPOLE, Mass., Aug. 13 (AP)—Inmates rioted outside a medication dispensary at the Massachusetts State Prison in an attempt to steal drugs late last night, injuring nine guards. . . . Two guards were stabbed and five others beaten as the inmates pushed their way into the 'pill' room, yelling, thrashing and literally gobbling down as many pills as they could at one time. . . . State Police Cpl. James Dunne, who led the squad equipped with 12-gauge shotguns, gas masks and crash helmets, said about 18 of the inmates were reeling 'on Cloud Nine' when he arrived. . . .

And from industry, where access to drugs is sufficiently relaxed not to require riots, I offer this item:

LOS ANGELES, Oct. 9 (*Los Angeles Times*)—Use of illegal drugs in industry, especially among production-line workers, is so common that to arrest everybody who sold or used them would mean some plants would have to hire whole new shifts of employees, according to a police narcotics specialist. The drugs most commonly used are amphetamine sulfate compounds and barbiturate derivatives, which keep workers awake, or put them to sleep. . . .

Since it is forbidden to peddle or "push" most drugs, including whisky, on television, Madison Avenue has responded to the

double dilemma of addiction by advertising aspirin as though it were *the* drug for every tribulation we must undergo. On television we are shown scenes in which mothers snap at their children, employers lose their tempers with employees. With only an awkward swipe at the questionable ethics of permitting this poor old headache remedy to carry such a heavy burden, advertisers show these embattled and suffering creatures putting one hand to their heads while a kindly neighbour advises them that this new aspirin combination is the perfect cure for "tension." The happy scenes following their use of the drug are deliberate efforts to imitate the style in which the pharmaceutical companies persuade physicians of the virtues of their products.

Most touching are aspirin commercials in which an aging movie star, long past his prime and no longer regularly employed, sits thoughtfully in his well-appointed study, telling the television audience that movie-making is a hectic and demanding affair. To avoid tension and headache, intrinsic to such activity, he has always resorted to this particular remedy.

The heart of addiction

Although probably unintentional, such a commercial goes to the heart of addiction, for we must contemplate the pathos of this formerly glamorous creature whose powers have so dwindled that he is reduced to doing headache commercials in which, fooling no one, he pretends nothing has changed. As he holds his bottle of pills to the audience, he seems to say life is really impossible without these pills. But we know, and he knows, that aspirin is not enough; for the vast restitution he demands of life, more powerful drugs are needed.

Should he seek them, he will not have to resort to any illicit drug traffic. He will have no trouble finding a physician who will prescribe amphetamines or psychic energizers to brighten his mood as he waits for calls from his agent. And if the phone refuses to ring, one or several of the many tranquillizers can be prescribed so that he can endure the waiting. Whatever insomnia may have originally been his lot will now be painfully

exacerbated by his drug-taking, so that other sedatives—fortified often by alcohol—will insure his sleeping. As he moves from one drug to another, mixing and testing the chemicals he believes his state requires and countering their disagreeable effects with still other chemicals, from time to time the sheer immodest scope of his undertaking will strike him: he has become a deranged chemist, his only laboratory his own poor body.

Instant insight

No matter how haggard that body becomes, he must unfortunately depend on it for fresh chemical inspiration. And, if everything else fails, there is LSD for instant revelation—if not wisdom—about the pretentious games that have brought him to this impasse, allowing him the death and re-birth that are now accepted pieties of the LSD mystique.

While it is true that the medical profession and the pharmaceutical industry together are the largest and most powerful group of pushers for the new drugs, I see no conspiracy on their part to make addicts of us all. It has long been common knowledge that physicians are the most devoted users of the drugs they prescribe, unlike the more disreputable pushers whose livelihood depends on abstaining from the drugs they peddle. The men who devise and merchandise these pills and the physicians who dispense them are, by and large, decent human beings who share the same disability of will that afflicts everyone.

Believing, as we do, that we should be able to will ourselves to be calm, cheerful, thin, industrious, creative—and, moreover to have a good night's sleep—they simply provide the products to collaborate in such willing. If the satisfactions turn out to be short-lived and spurious, and if their cost in terms of emotion, intellect and physical health is disagreeable, these scientists are ready to concoct new drugs to counter this discomfort. In other words, they offer us always new chances—virtually to the point of extinction—to will away the unhappiness that comes from willing ourselves to be happy.

Recently, Dr. Carroll L. Witten, president-elect of the Amer

an Academy of General Practice, was quoted in the press as being in agreement with a report issued this year by the United Nations Commission on Narcotics, which expressed concern over the alarming rise in the sale of barbiturates, tranquilizers and amphetamines."

The report suggested further that the "explosive expansion of the use of drugs . . . was most likely a result of their being used less as medication than as agents for producing sleep, a sense of happiness and relaxation."

Dr. Witten declared: "I believe these drugs are not only used wrongly, to excess and without adequate indication, but that in many cases their indiscriminate use has led to dependency, habituation and addiction, with all of the consequent results thereof."

Dr. Witten said he was referring specifically to the non-narcotic drugs used as "psychic energizers, stimulators, activators, deactivators, depressants, alleviators, levellers, elevators or in whatever imaginative category one might place them. One must note with a great deal of alarm," he declared, "that the vast majority of cases first obtained their drugs through the prescription of a physician."

Demand outruns supply

If willing what cannot be willed has led us to being addicted to addiction, it would seem that our addictive appetite will always be more than a match for the ever-mounting number of chemicals that are fashioned to gratify that appetite. And even if we eliminate actual drugs from our consideration, the addictive possibilities are endless: cigarettes, chocolate, detective and spy stories, football on television, psychoanalysis—to mention only a few of my own excesses, which I would unhesitatingly characterize as addictive. Everyone, I am convinced, has his own list, as well as another more prideful list of those objects and activities whose addictive claims he has successfully withstood.

If the term is not to be altogether meaningless, some distinction must now be made between one addiction and another. Con-

cretely, when it comes to putting myself to sleep, how shall I distinguish between detective stories and sleeping pills? Or between watching football on TV, and enduring my Sunday with tranquillizers? Or completing a tedious chore on amphetamine and procrastinating as usual?

Drugs work better

The first generalization I would make about these sets of alternatives is that in an immediate sense drugs are clearly more effective. Detective stories, for me at least, are not entirely reliable as sedatives. If the story is so poor as to outrage or challenge my diminished sensibilities, I am in trouble, whereas I can always take another sleeping pill.

Watching even an exciting, well-played football game on TV I cannot entirely obliterate from my awareness the perception that there are other ways in which I could more profitably spend my time. And if the game is inept and boring and still I do not turn the set off, my view of my condition is grim indeed. On the other hand, with tranquillizers, I could achieve a state of not-unpleasant relaxation, unruffled by the sort of nagging self-concern that interrupts my absorption with even a good football game.

It is the last set of alternatives that will prove the most troublesome. If I have a group of evaluations of psychoanalytic candidates to write, I am inclined to put it off. The reasons or rationalizations for my procrastination will be various: I don't feel well; such reports are too tedious to be endured; I resent the bureaucratic rule requiring these reports; I am reluctant to set myself up as a judge of the performance of these young men; I am convinced I am not equal to the imaginative discriminations that would do these human beings justice.

With a dose of amphetamine, however, my self-concern, with its associated fatigue and hesitations and doubts, will vanish so that in a single-minded way I shall vigorously engage in my task. Within a few hours all the evaluations will be completed. Like a schoolboy who has at the last minute finished his term

aper, I shall feel relieved and virtuous to have at long last done what my organization demands of me.

Reading over my reports after I have recovered from the rug, I may be chagrined to note a breathless, assertive and yet self-indulgent quality to my writing that did not trouble me at the time. But I can counter my dissatisfaction by assuring myself these deficiencies matter very little, since I have done all that was asked of me. It was my own sin of pride that initially led me to regard my task as such an intricate and demanding responsibility. Besides, I will tell myself, wasn't it a choice between doing nothing and doing something, however imperfectly?

Thus will my mood of accomplishment prevail, helping me to disown my self-criticism and perhaps persuading me, since I won't have to read these reports again, that I had indeed been discriminating in preparing them. And my earlier doubts as to whether these evaluations should have been written at all can be postponed for another time.

f you want contentment

The sensation of being a going, if unquestioning, member of society should not be slighted, because it is hard to come by these days. Nevertheless, we must concede that while the drugs in these sets of alternatives may be more effective, their effectiveness is largely dependent on the chemical deadening of important imaginative and critical capacities, whose privileges are admittedly problematic. Practically every drug invented, from opium to LSD, has had its champions in both science and the arts, who insisted that their particular brew was not only not reductive but was actually heightening of human potentiality.

The objective evidence for their claims, however, has always been depressing and of the same order as my own reports, whether it be the music played under marihuana or heroin, the pictures painted and the poetry composed under LSD, the deadlines met by means of amphetamines, or even—perhaps especially—the perceptions and insights granted by drugs.

At this point, the question must be raised: aren't other addictions—non-drug addictions—also reductive? The answer has to be a qualified affirmative. The friend watching me glued for hours to the television set, isolated from all intelligible life, impervious to the claims of my children who have waited all week to have a few moments with me, has to find my human condition bizarre, to say the least.

Escapes from freedom

Far more seriously incapacitating, of course, are those non-drug addictions that involve ideas and habits of thought. Those who over the years develop an addiction to shopworn ideologies—religious, scientific, political, aesthetic, psychological—in a sense forfeit, in wilful dedication, the very capacities of spirit and intellect that might set them free.

Nevertheless, there is a difference between drugs and no drugs. While disdain and denial of these capacities will cause them to shrivel and grow ever more paralysed as years go by, there remains the possibility of a response, however minimal at first, to some human claim. Chemical deadening, on the other hand, if pursued, will, by its very nature, render such capacities eventually heedless to any call.

But to return to my evaluations of those psychoanalytic candidates: my will, with the help of amphetamine, has had its indiscriminating way in my reports, without the reflective give-and-take between me and my writing that could be called dialogic, causing this enterprise to resemble other headstrong monologic sprees in which the speaker is deaf and blind to those about him at the same time that he is convinced of a singular openness and freedom and mutuality to the exchange.

The non-user has a dispiriting effect on groups enthusiastically consolidated by such convictions, so that they would prefer him to find his own sober companions. And his response to them will be marked by his discouraged observation that, despite the cries of mutual congratulations, all he can hear are colliding monologues, breathlessly composed so that each par-

icipant gives in to his own worst headstrong and literal-minded inclinations.

The person who ordinarily must guard against his habit of fast abstraction now becomes even more abstract in his theoretical pronouncements. The person top-heavy with aesthetic sensibility becomes even more indulgent to that side of himself, abdicating his ability to temper such aestheticism with moral and psychological discriminations.

The most blatant examples of the literal-minded aspect of the drugged state come from the public writings on LSD, but it is by no means restricted to this particular drug. Under LSD, it would seem, one is at the mercy of any fancy that strikes him, much like the hypnotic subject responding to the commands of the hypnotist. Should he note that his hand is ugly, that hand becomes literally swollen and grotesque. Should the thought strike him that he is alone in the world, he will quickly and literally find himself as one small mortal in the midst of an endless desolate landscape. In each instance, what properly should be no more than a beginning metaphor has been exalted, at the behest of the will, into physical reality. Similarly, the death undergone with LSD can be regarded as more deathly than death itself. In a section, jarringly titled "Running Smack Into Your Essence," of "LSD: The Acid Test," published in *Ramparts*, one evangelist, Donavan Bess, wrote:

The lonely death

"The psychedelic death is especially lonely—lonelier, perhaps, than for the soldier who physically dies in a Vietnamese field hospital. He at least has the comfort of cuddling up in the image of his mother. Under LSD you have no such bourgeois comfort; you have no familial figure at all. You die grown up. If you can hang onto that, afterward, you can offer society some adult values. You came to this point in a rite of passage as explicit, as terrible and as meaningful as those rites used in aboriginal Australia."

In considering the addictive state that may result from drugs,

narcotic and non-narcotic, I must of course neglect the specific effects each drug has or purports to have on the central nervous system. An unfortunate consequence of such neglect will be to give the false impression that my own addiction to non-addiction has led me to advocate an impossibly ascetic life, requiring abstention from all chemical assistance, come what may. Let me quickly insist that all the drugs I have mentioned may be taken in non-addictive ways for reasons that are appropriate to the effects of the particular drug. This is to say, there are times when prolonged sleeplessness can and should be interrupted by sedatives, just as there are painful occasions when morphine is the only answer. Even amphetamines may allow the completion of a low-level chore.

Danger: executive speed-heads

The difficulty here, however, as indicated earlier, is that the mood of accomplishment may persuade us to disregard the quality, or lack of quality, of our performance—not to mention the disagreeable drug side-effects—so that we turn to the drug in situations that require more of our wits and equanimity than amphetamines will allow. Perhaps a greater danger, as the use of amphetamines becomes more widespread, is that the deadlines asked of us are increasingly determined by the amphetamine intoxications of those who ask.

Another illustration of the manner in which the drugged state influences social values is suggested by the aspirin commercials referred to in this article. The writers of these advertisements seem to be selling not only aspirin but also their conviction—possibly arrived at through their own experience with tranquillizers—that our ordinary difficulties, since they are only subjective and therefore not worth contending with, are best erased with drugs. Thus, an advertisement for meprobamate, addressed to physicians, shows a picture of an overwrought mother with a child, the caption reading: “Her kind of pressures last all day . . . shouldn’t her tranquilizers?”

For the sake of completeness, alcohol and marihuana are two

rugs whose object is explicitly pleasure, and which may be used non-addictively. However, too much has been made recently by the younger generation of the non-addictive properties of marijuana simply because its physical effects are less dramatic than those of alcohol and other drugs. More dramatic is its effect upon relation: the pleasures of monologue experienced as dialogue under the drug persist as a habit of tolerance for such illusion—which in a sense is the very issue of addiction.

Let us consider briefly the addictive course—from initial pleasure to ultimate disaster—that will result from prolonged and excessive use of any of the drugs I have mentioned, singly or in combination.

The first subjective experience of wholeness and the pleasure accompanying it will acquire its intensity partly through contrast with the discomfort that preceded the use of the drug and partly through the manner a particular drug answers a particular person's need at a particular time. Thus, users are labeled according to their preferences as "up-heads" or "speed-heads," "down-heads," "acid-heads," "pot-heads," "lushes," "junkies."

With further sophistication and availability, and the co-operation of the medical profession, drug users already are specializing and availing themselves more of other products and mixtures of products. But the initial feeling of well-being is difficult to duplicate precisely, regardless of the ingenuity of the user. As the drug and the state associated with it begin to wear off, the user returns to a world that has lost none of its oppressiveness and with which, in the midst of the drug hangover, he feels less able to cope.

Transcendence at will

The distance between himself and the wholeness he sought has grown somewhat, so that he is now vulnerable to the beginning belief that the relief the drug afforded is an extraordinary sort of transcendence, which his usual life with others cannot provide except in the occasional unpredictable and surprising manner in which such moments arise. In other words, he has been burned

by the demonic and addictive notion that he need not wait on life for the transcendence he seeks, that he may invoke it whenever he so decrees or wills by returning to the drug or drugs that first allowed him this remarkable feeling.

With this seeming triumph of his will, he will be more impatient of the often frustrating give-and-take of life without drugs, wilfully demanding his well-being of those about him, and thereby suffering even more the penalties of such willing. In a sense, he insists—futilely—that life now be his drug.

A lesser person

Needless to say, his mounting impatience will be inimical to the exercise or development of such qualities as imagination, judgement, humour, tact. And should he glimpse—however dimly—his impoverishment, he may wish to believe that these qualities at least can return with drugs, disowning the evidence accumulating to the contrary. However, without these qualities he is more and more confined to the exigencies of the moment for he can no longer really remember his drug experience in the past nor can he imagine what may follow. As his intolerance for life without drugs increases, his competence for such life diminishes, so that, with every return to the drug, he is—in the spirit of Heraclitus—a different and lesser person who attempts to cross the same stream twice.

What seemed the feeling of transcendence at the beginning has long since been abandoned as his drug goal in favour merely of getting from one moment to the next, in favour of mindlessly and minimally staying alive. What began with his will to decree well-being for himself without having to wait on life now culminates in almost a paralysis of will for every trivial action even getting dressed or feeding himself. It is as though all the taken-for-granted stream of activity had disintegrated into a swarm of tiny yet insurmountable enterprises for his will, every one seeming to require further drugs for its accomplishment.

As a result of the bombardment of his body by such large dosages of drugs, his physical debilitation grows extreme. Yet

ven this bodily exhaustion and derangement offers a last resort to the will, which is now unequal to practically every small movement in his world. Unlike other depleting illnesses that mysteriously overtake us, this one has been induced by himself and seems to be within his control. That is, he may try to assuage his agonies with more chemicals, or he can withdraw the noxious agent so that his body can slowly recover its strength.

All other dramas in which his will has been involved have given way now to the one small immediate drama of whether he shall live or die to this world. It is a far cry from the transcendence he sought originally, but every addict knows that the drama of his failing body is the last plot his will must confront. Unlike the proponents of LSD, he is beyond metaphysical conceits about the meaning of dying to this world, nor will he glamorize recovery, to whatever degree it may occur, as spiritual rebirth.

Nietzsche, I believe, was not as interested in theological argument about the disappearance of the divine will in our lives as he was in the consequences of its disappearance. Today, the evidence is in. Out of disbelief we have impudently assumed that all of life is now subject to our own will. And the disasters that have come from willing what cannot be willed have not brought us to any modesty about our presumptions. Instead we have turned to chemicals, which seem to enhance our wilful strivings. It was only a question of time before man in his desperation would locate divinity in drugs, and on that artificial rock build his church.

Check Your Mental Health

By William C. Menninger, M.D.

I believe strongly in physical checkups; a lot of people neglect them because they feel all right, but I think they are essential. I'm also convinced that it would be an intelligent practice to take an emotional checkup along with that physical checkup and I have some specific suggestions about your mental health.

Look where you're going

I recommend strongly that everyone set aside a little time—once a year, at least—to decide where he is going, what are his priorities, what are his ambitions and what are his aspirations. Do you know whether you are going in the right direction, and, most of all, where you want to get to? Not just in your business alone, but in the important personal areas: the atmosphere in your home, your relations with the members of your family, your own feelings of status and worthwhileness in life, your own dignity, your own integrity.

Take a vacation

I haven't any reservation about recommending strongly that you have an avocation, and also that you take vacations. I can tell you that both are good for your mental health. Don't be the kind of fellow who deprives himself—who says that he hasn't taken a vacation for five years, as if that were a virtue. It only reflects either bad judgement on your part or serious aggression towards your family, or both. In addition, I have no reservations in prescribing for any patient I see that his life will be richer if he has some hobbies, and lots richer if he takes them seriously.

Dr. Menninger was President of the Menninger Foundation in Topeka, Kansas until his death last year. This article was condensed from a paper presented at the Menninger Foundation's seminars for executives, and originally appeared in *This Week* magazine under the title, "What a Psychiatrist Would Like to Know About You." It was reprinted last year in the issue of the *Menninger Quarterly* that was dedicated to Dr. Will's memory. Copyright, 1962, by the United News Papers Magazine Corporation.

An emotional checkup

If I were giving you an emotional checkup, these are some of the things I would want to know about you:

How are you with people?

I would first inquire about your own personal relationships. How do you get along with other people? Whom do you like? Whom don't you like, and why? Are you one of those temperamental fellows who is "on" one day and "off" the next? How good are your personal relationships?

How are you under pressure?

A second point I would want to know is how you handle a situation when the going gets rough. Do you lose your temper? Do you get jittery? Do you become paralysed? Do you get so anxious that you can't function? I would want to know how you handle reality at its more difficult moments.

How good a giver are you?

I'd like to know how much fun you have in constructive, creative giving of yourself. As infants we were all on the receiving end; but the mature adult ought to find his greater satisfactions in giving of himself—to constructive things, to people, to ideas.

Can you take frustration?

I would like to find out how you accept frustration. Are you still such an immature character that you must have what you want when you want it? And if you don't get what you want, do you pick up your marbles and leave the game? We have to work for the things we want, and it takes time and planning and dedication to get them. We have to accept frustration for the sake of future gain. How well do you know that?

How do you handle tension?

Then I want to find out how free you are of anxiety. What outlets do you have when you are tense and anxious? All of us are upset at times—realistically so when the pressure mounts. But if you are chronically full of tension you are sick. When

you are under pressure and feel some tension, then I want to know how you handle it and what you do about it.

Can you ask for help?

Finally, I want to know: if you know you're troubled, do you go and get help? Lots of people don't. They think they can bull it through, procrastinate and stay inefficient, instead of having the good judgement to get help when it is needed.

The courage to see yourself

The essence of all these suggestions is the recognition that we have to have courage to look at ourselves before we look at other people. The need begins in our own minds. We are part of other people, and it is only as we have the courage to see how we can handle our own emotions normally and constructively that we can eliminate some of our own selfishness, our own prejudices, our own resentments, our own bigotry.

Only in this way can we increase our own capacity for humility, to be able—in the broad sense of the word—to love.

Genetic Cell Damage from LSD?

By Harold Kalant, M.D., B.Sc., Ph.D.

Many people have discussed, from differing points of view, the question whether LSD can cause cumulative or permanent damage to the user; but there has been little concern until recently with the possibility that the drug may cause genetic damage that could be passed on to the children of users. A recent report by three workers at the State University of New York in Buffalo raises this question in a manner that cannot be dismissed lightly.

The researchers are Maimon M. Cohen and Michelle J. Mariello of the university's pediatrics department and of the Buffalo Children's Hospital, and Nathan Back of the university's department of biochemical pharmacology. Their report appeared in the journal *Science* (Vol. 155, No. 3768, March 17, 1967) under the title "Chromosomal Damage in Human Leukocytes Induced by Lysergic Acid Diethylamide."

Chromosomes give warning

It has been known for some time that excessive radiation, and certain drugs that are used either experimentally or in the treatment of cancer, can cause congenital anomalies in the children of persons who have been so exposed or treated. These anomalies are produced by chemical changes in the DNA (deoxyribonucleic acid) of the chromosomes of either or both parents. DNA is the substance that makes up the genes and transmits the coded information, both in the sperm of the male and in the ovum or egg of the female, that governs the development of the infant from the time at which the union of sperm and egg takes place. Alterations in the chemical structure of the DNA characteristically give rise also to a weakening of the chromosome structure, which may result in breakage of the chromosomes. Thus, when chromosome breakage is observed—as it can be under

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the microscope—it is a sign of possible DNA alterations that may cause congenital abnormalities.

When DNA alteration occurs, it is permanent and becomes part of the hereditary makeup of the individual. Such mutations do occur spontaneously in normal people—probably because of cosmic radiation and other physical and chemical factors in our environment—and are probably the basis of the genetic changes that underlie the process of evolution. However, for every mutation that is beneficial there are literally thousands that are either of no biological value or actually harmful. It is impossible either to predict or to direct the type of mutation that will occur in any given case, and the great majority of genetic changes that are induced by any drug or treatment are harmful.

Produced more breakage

The report by Cohen and his associates describes experiments in which normal leucocytes—white blood cells—from human donors were exposed to the action of LSD in concentrations ranging from .001 to 10 micrograms per millilitre, for periods of 4, 24 or 48 hours. They found that *even the lowest* concentration, for the shortest period of exposure, produced appreciably more chromosome breakage than was seen in untreated control cultures under the same conditions.

What gives this report particular significance in relation to the consumption of LSD by humans is the fact that the concentrations Cohen's team used were well within the range that might be predicted in the systems of persons who consume LSD, on the basis of the doses that are commonly taken. For example, a dose commonly used for an LSD trip is 200 micrograms. If this amount were distributed uniformly throughout the whole water content of the body, it would give a concentration of approximately 4 to 5 micrograms per litre. This is four or five times the lowest concentration that produced a significant increase in the degree of chromosome breakage in the Buffalo study.

In fact, the drug is not uniformly distributed throughout the body: the concentrations in certain body tissues are considerably

higher than in others.¹ No data are available for testis and ovary issues; but it seems likely, on other grounds, that they are among the tissues in which higher drug concentrations occur.

The same investigators examined blood cells from a 51-year-old schizophrenic who had been given LSD for therapeutic reasons some fifteen times over a six-year period, in doses ranging from 80 to 200 micrograms. The rate of chromosome breakage in his cells was more than three times the normal rate.

As Cohen and his colleagues point out in their paper, there is no proof that such an action on blood cells in a tissue culture necessarily resembles that which might be produced in sperm or egg cells in a human user of LSD. However, analogy with the effects of other drugs and other physical agents suggests that such changes very frequently do go parallel. Therefore, while one cannot state on the basis of the present evidence that LSD is likely to produce genetic damage in its users, the possibility must be taken very seriously until further evidence is available. In view of this possibility, which remains to be investigated,² one may well ask whether the claimed gains or pleasures produced by LSD are enough to warrant the possible risk, not only to the users themselves, but to their future children.

No report from the clinics

LSD has been used heavily by certain groups in the North American population for the past few years, and many children have been born of LSD users. This being so, one may wonder why no tendency towards excessive congenital abnormality in the children of LSD users has yet been reported by clinical observers. Since no such tendency has been reported as yet, does this mean that the risk indicated in the Buffalo study is non-existent?

The answer is that it takes a considerable time to establish

J. Axelrod, R. O. Brady, B. Witkop and E. V. Evarts, *Annals of the New York Academy of Sciences*, Vol. 66, pp. 435-444, 1957.

Time magazine reported (March 24, 1967) that blood specimens from patients who have become psychotic after taking LSD are being sent to Buffalo "to see whether the phenomenon is widespread."

whether a connection exists between the consumption of any drug and the occurrence of any congenital abnormality. In the case of the thalidomide babies, the abnormalities that occurred were of a specific and striking type, and they occurred because of a particular metabolic effect of the drug at a critical stage in the development of the embryo; the connection was therefore obvious, and was quickly recognized. However, if the effect of a given drug or treatment is merely to increase the frequency of certain congenital defects that also occur spontaneously, it may take many years of observation to provide the statistical evidence.

The public reads eagerly of new drugs to bring about a temporary serenity; some of us would be more interested in drugs that would evoke aspirations or spur a desire for learning or increase displeasure in wastefulness and self-preoccupation. We cannot be enthusiastic about chemical methods to produce a state of *sans souci*; what the world needs and what more human beings need, for their own mental health and that of their universe, is not to care less but to care more. For this we have no chemicals. There are no drugs "to keep the soul alert with noble discontent."

—Karl Menninger, *The Vital Balance*
(New York: The Viking Press, 1963)

Aftercare of Drug Addicts:

The Missing Link in Rehabilitation

By Rev. Daniel Egan, S.A., A.B., M.A.

All that is good and worthwhile in human society stems from our acceptance of the basic reality of man's inherent dignity as a human person. Once a culture denies or forgets this fact, then society suffers. We begin to believe, wrongly, that man's value and dignity comes from society or the state, and not from God. What society gives, society can take away. What God gives, only God can take away. Society may forget man's dignity, but God can't.

Man has a physical body like a brute animal, and like a brute animal he has blood and emotions and urges and all that. But man is more. He is a rational animal. He can think and reflect—and read papers at a conference on addiction. He doesn't have to act by instinct or chance or blind force. Man has free will. He can be blamed and rewarded.

It is only because man has a spiritual and immortal soul that all this is so. And it is only because man is a human person with such noble dignity and destiny inherent in his soul that we are compelled to rehabilitate persons who have become drug addicts. When any profession forgets or ignores man's dignity and eternal destiny, then man becomes a mere object of research, a thing to be talked about, a topic of verbal dissection.

The addicted person will always be more important than addiction. We don't research the effect of goofballs on the brain,

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but rather the effect of goofballs on an organ of the central nervous system through which the human person thinks. We don't research methadone, but rather how methadone can help some human persons live normally in society, in keeping with their dignity as people of God. All this is basic to the whole concept and philosophy of any rehabilitation program for drug addicts.

Rehabilitate what?

The ultimate aim of all research, treatment and aftercare is rehabilitation. But without getting into semantics, "rehabilitation" may not be the best word to use because we really don't or can't "rehabilitate" most drug addicts. The Latin word *rehabilitare* means to restore, to give back what one lost, to regain a former condition. Now, you can't restore what a person never had. If most addicts started on drugs at fifteen, then it means they never finished school and they never held or were prepared to hold a permanent job. It means that from the age of fifteen they descended into a sub-culture so unstable and rootless that we find very little to regain, restore or rebuild. Once addicted, all their waking hours are spent in search of drugs or the money to buy them. When not doing this, they're in a prison, a hospital, or the morgue. What, then, is there to restore or rehabilitate? When ten years of one's life have been oriented towards nothing but heroin and you remove the heroin, what fills the void? Rehabilitate what?

Rehabilitation, then, is a long, sustained, frustrating process of rebirth, re-education, and growth. Often, the only thing we have to begin with is the human spirit. The will to live; the will to find happiness instead of passing pleasure; the will to live without guilt; the will to start the day with coffee and a prayer instead of a fix and a curse: these are spiritual motivations that rise up from man's soul—his will—and not from stimuli or brain waves. This has been the most exciting thing to watch at Synanon, Daytop, the Village Haven, or those on the New York City methadone program: people doing and enjoying straight things

they never did before; people beginning to live and grow; a methadone girl going to her first dance in seven years; a Daytop boy ironing a shirt for the first time in his life; a Village Haven girl baking her first pie; a Synanon graduate starting a new foundation; only those who know addicts feel like cheering at such miracles.

The chain of rehabilitation is only as strong as its weakest link; if there's a link missing, there's no chain. It is my contention that up to recent years there has been little or no rehabilitation of drug addicts, because the link of aftercare has been either totally or virtually missing. In the past few years, aftercare programs have begun to develop—but they are almost completely inadequate. I don't mean that the programs themselves are lacking in dedication or know-how. I mean they can't cope with all the people who need their services.

No adequate aftercare

What good is research if it isn't aimed at treatment? And what good is treatment if it isn't followed up with immediate, intelligent aftercare? Up to now, untold millions of dollars have been spent—some would say wasted—on research and treatment in the field of drug addiction, and all for what? Supposedly, it was all aimed at curing or rehabilitating the addict, but has it? Research has led to better treatment of addicts in our drug hospitals, but the link between treatment and rehabilitation has been missing. There is virtually no adequate aftercare of drug addicts leaving prisons or hospitals.

As a side remark, may I say that I don't like the word "treatment." It seems too impersonal. If "care" and "cure" are almost synonymous terms in medical practice, then care is equally essential in the rehabilitation of drug addicts. But no one can really give rehabilitating medical care unless he really *cares*. "Care," then, is more of an attitude than a treatment. We treat an abscess, but we care for the addict *who has* an abscess. A doctor may lance a painful primary abscess in an addict's arm with precise medical surgery. But if, while treating the abscess,

the tone of his voice and the look in his face reveals his open disgust for addicts, then his treatment will have no lasting motivating effect on the long-range goal of rehabilitation.

In trying to rehabilitate addicts over the years, I have made many mistakes. But I had to learn from mistakes, and not from human lives. So I had to learn fast. It was in the course of this learning process, living with addicts day and night, that I was forced to make basic conclusions about the pathetically useless and expensive methods of dealing with drug addicts that only perpetuated the problem instead of solving it. When one studies the problem of addiction many miles from its source, there is seldom a note of urgency in seeking its solution. One becomes a bit too objective, too professional. It is only when one lives with people who are addicts, gets involved in their tragic lives, that time is important and the same mistakes can't be repeated and repeated.

No help in prison

Every year more than fourteen hundred women are admitted as prisoners to the Women's House of Detention in New York City. At least eighty-five per cent of these are drug addicts. So in fifteen years I've met thousands of female addicts. In my early days I used to actually pray that some would be arrested—"At least in prison they'd be safe." After identifying so many addicts in the city morgue; seeing so many in hospitals after they were beaten, stabbed, raped; meeting them sick in the streets at night existing on nothing but coffee, cigarettes and junk, I was relieved, and still am, when I met them next day in prison. "At least here she will be rehabilitated; here she will get some psychotherapy. Here she'll be helped." But now I know that prison of itself permanently helps no one. It doesn't permanently help society either. Whatever help it gives the addicts is lost the day of release, because there's no adequate aftercare to pick up and continue the help. As for psychiatric help, I believe it's the exception, rather than the rule, that an inmate gets any personal, individual psychiatric care unless it is aimed at coping with some

stitutional tension or disciplinary problem within the prison walls. In the few cases where real psychotherapy is given, it is usually wasted because after release there's no contact with the same psychiatrist *in* the community. In a word, adequate aftercare is missing.

Hospitals not the answer

There was a time, too, when I was convinced that the hospital was the answer. Fifteen years ago, when I met my first drug addict and was shocked to discover that no hospital would admit her, I was determined that hospital beds were the answer. So I pressured and lobbied to get them into hospitals. Bit by bit, or bed by bed, I was able—through blarney, flattery, adulation, cajolery and a few threats—to get more and more addicts into public hospital wards. In most cases, once they saw what an addict looked like and saw how well they responded to genuine medical concern, doctors were more than kind and sympathetic with addict patients. But then what? All those hours of dedicated and expensive medical care went right down the drain almost the very day of discharge from the hospital. Why? Because there was no adequate aftercare in the community to pick up and continue the care.

Build a halfway house

Today I am firm in my conviction that the hospital is not the answer. It may be part of the answer, but it is not even a necessary part. If I had a few million dollars today and was told to use it to rehabilitate drug addicts, I'd skip the hospital and build myself a dream of a Halfway House that would give total patient care right in the community. Certainly, the ideal would be to have both a community hospital for quick medical detoxification, and then immediate aftercare in the community. But if I could have only one or the other service, the hospital or the community aftercare, I'd rather skip the hospital and take the aftercare. With or without medical help, I'd withdraw the addict with methadone in a special section of my Halfway House, supervised

by hand-picked, dedicated clean addicts. I'd then get her totally involved in an aftercare program managed by other clean, involved addicts.

Hospitals have revolving doors

This may be a very unpopular opinion in the face of the constant cries for more detoxification hospitals, but this conference might well go on record as at least questioning the need. I would rather propose that we use more wisely the facilities we have, but that we spend more money on aftercare. However, it is the sacred and serious responsibility of the medical profession and all other professions and disciplines concerned with drug addiction in Illinois, and especially in metropolitan Chicago, to evaluate their own situation realistically and determine if there are enough hospital beds available for those who are motivated enough to want hospital care. Here in Chicago, after three days of studying the scene, I'm sure you need more beds. But I have my suspicions that in New York City the supply of beds may be equal to the legitimate demand. By that I mean there aren't that many addicts who really want to stop addiction to warrant building more hospitals. Like prisons in their rate of recidivism, detoxification hospitals in New York City have rapidly developed their own peculiar brand of revolving doors that swing addicts in and out for reasons that should be obvious.

Detoxification is easy

Those who have worked for many years in the field of drug addiction can see many reasons why detoxification hospitals alone are not the answer. From my look at the total picture, I wouldn't blame the hospital at all. It is doing only what it was set up to do: detoxify the addict. But detoxification, at least today, is the easiest and cheapest step in rehabilitation. It doesn't take two weeks to withdraw an addict from today's junk. But once withdrawn, then what? If an addict is not properly motivated before admission, he will very probably be back on drugs within a few hours after discharge. Even if he admitted himself

or the right motive, he will still be re-addicted just as quickly if there is no immediate, adequate program of total aftercare as soon as he leaves.

Medical doctors know from their training and experience in obstetrics that successful childbirth depends on proper pre-natal care. Good surgeons are often very reluctant to operate on a patient who is convinced beforehand that he will not survive the operation. Medical men should apply the same wisdom and common sense to the sickness of drug addiction. If there is no conditioning or preparation beforehand, then the results may be successful only in spite of you—not because of you. An addict's attitudes, his motivation, his hopes and plans, his guilt—all this must be cared for *before* admission. If the addict is hopelessly convinced that he is doomed to return to drugs even before he enters the hospital, then he *is* doomed to be re-addicted. But, in a new and daring approach, why couldn't we begin our aftercare even before he enters the hospital?

Our approach has been wrong

To all who are sickened by seeing the same addicts revolving in and out of the same hospitals and prisons, it must be painfully obvious by now that something must be wrong in what we're doing or in the way we're doing it. As someone once said in desperation, "Never were so many so wrong for so long about so many things. . . ." We can't pass it off by blaming it all on the addict. Neither can we blame the present attitudes of the Federal Bureau of Narcotics. I'm convinced that our whole approach has been wrong—so wrong in its philosophy and mechanics that we have unknowingly perpetuated the problem. And it is a mystery to me that so many intelligent and dedicated people have kept in motion a program of rehabilitating addicts that has proven to be so hopeless, so futile, so discouraging and so expensive.

In a word, the method is wrong. It is wrong in the way it begins and in the way it ends. It ends when it should be beginning—and it begins on a futile note of despair. Aftercare

depends on the way an addict enters a hospital and on the way he leaves it.

In accordance with man's nature and dignity as a thinking creature, traditional philosophy teaches that the interior order of intention must precede the exterior order of action. "Agitur sequitur esse"—motivation comes before execution. If an addict's interior order of motivation is all wrong, then his external execution will be all wrong. This is simple but sound philosophy. And without a true philosophy of man, every related discipline is plain stupidity and a waste of time.

Methadone maintenance

Reducing this to the problem of drug addiction, let's face it: if a man can't function without drugs, then it's an expensive waste of time to detoxify him. It perpetuates the problem and keeps that revolving door swinging. All of us must work together, then, to isolate those who *really* can't, from those who only *think* they can't. If all the caring professions decide that some few addicted persons cannot function in society without drugs, then why not give it to them—and call it medication, which it really is. Why force them to live as criminals, to be continually arrested, convicted, imprisoned, released and re-addicted, and then die as criminals?

I was interrupted at this point in writing this paper by a tragic incident that spells out my argument.

Back in July, two female addicts were simultaneously released from the Women's House of Detention in New York City. Lillian has just served her seventh sentence, Rose her 117th. Lillian was suffering from such severe depression and anxiety that even I could see she really needed some form of drugs to get through the day. But there was no aftercare for Lillian. She almost wept on the corner as she said, "Father, I can't promise you I won't cop a fix in an hour. I know I will. I need it." She did need something! If I had had a handful of methadone pills in my pocket at the time, I would have given her some on the spot. Not having any, I begged her to go up to Manhattan Gen-

ral Hospital and try to get on Dr. Marie Nyswander's program. Now the tragic interruption. I just returned from Bellevue Hospital after identifying Lillian's body. She was in the morgue five days—no one would claim her. She died of tetanus—an awful way to die: painful spasms, rigid body—all from a dirty needle in an open sore. Poor Lillian never made the methadone program. If she had, she might be alive today and, perhaps, functioning to the limit of her capabilities.

Rose's story is more hopeful. It's better than a fifty-page paper on aftercare. During all those 117 sentences, she never *wanted* to stop drug addiction because she was convinced she couldn't. But she always added in despair: "Even if I wanted to stop, how could I? Where would I begin? Who'd help me?" On her 117th release from prison I convinced her, on the corner of 6th Avenue and 10th Street, that she really could stop if she wanted to, and then gave her her own reasons for wanting to stop.

straight for six months

"But where will I go? Where will I live? What'll I do? Who'll help me?" Such questions never frighten a non-addict, but they do panic an addict leaving a hospital or prison. Real aftercare answers all those questions. "No aftercare" is usually the excuse for returning to drugs. When I convinced Rose that I would help her, that she could have a private room of her own at our Village Haven Halfway House, where all her needs would be taken care of, where she wouldn't be alone and lonely, where she could get hope and encouragement and identity from other clean addicts—when I explained all this to Rose, it was as if a great weight was lifted from her whole person. I brought Rose to the Village Haven, and she's still there: the longest period—six months—free of drugs in over twenty years.

There is no one kind of aftercare that works best for every addict. The kind of aftercare Rose needed was never there when she stepped out of prison her previous 116 times. The kind of aftercare poor Lillian needed, she couldn't get.

I suggested earlier that our whole philosophy of rehabilitation

was wrong, in that too little effort was spent in properly motivating addicts *before* detoxification, and that the mechanics were wrong in ending rehabilitation before it had even begun.

Isolation is artificial

Let me stress the last first. In too many prisons and hospitals, addicts do nothing more than vegetate. At Synanon or Daytop they grow mentally, spiritually and emotionally—what rehabilitation programs they do have in most prisons and hospitals are aimed merely at keeping addicts busy, because inactivity leads to fights and drug talk. But as far as actually helping the addicted person to prepare for life in the community, this just isn't done in most cases. The vast majority of addicts don't know, on the day of discharge, where they will live or even how they will get their next meal. Actually, rehabilitation only begins with discharge, because only then is the addict returning to a real world. But if there is no immediate, adequate aftercare, how can there be rehabilitation? We seem to forget that not even personality can be understood apart from its social setting. How can psychiatry pin a label on an addicted person miles away from the addict's own social setting? Personality can have no meaning when studied apart from a true-to-life community of other persons.

Those in charge of any in-treatment program for addicts, be it in a hospital or prison, must begin to think less of the addict in the process of detoxification, and more in simple terms of his living and eating and working and shopping *in* the community. Where will he sleep tonight? How will he support himself tomorrow? Rehabilitation really begins with immediate aftercare, not with detoxification or ceramics. Rehabilitation *could* begin in a prison or hospital. But in most cases it does not. It ends even before it begins.

Because no one understands an addict the way an addict understands an addict, an addict is the best person in all the world to really help another addict. Maybe the simple repetition of the word "addict" will force us to remember him. You will

earn more about addiction and you will be taking the biggest step in licking the problem the day you do see and hear a group of Daytop graduates discussing rehabilitation. They are living proof of their total understanding of the problem and of the lasting help that addicts can give each other.

There just isn't any sense giving aftercare to those who don't want it. Those who don't want aftercare want only to return to drugs. So we must somehow separate the men from the boys. The right addicts, free from drugs, living straight, in conventional society, are the best people to contact other addicts and motivate them towards a new drug-free way of life. Those on a methadone program, using the program and not abusing it, are the best salesmen for its new, non-criminal and more productive way of living. Not to harness the zeal, experience, understanding and dedication of these people is almost criminal.

The aftercare they are not encouraged to give is what's missing in all rehabilitation programs up to now. So let's beg their help.

Aftercare is an attitude

Now, before spelling out any specific forms of aftercare, may I stress again that aftercare is more of an attitude than a place or a program. Unless we develop the habitual mental conviction that aftercare is an absolute and urgent necessity, then there just won't *be* any. Up to now, we have not been convinced of this urgent and absolute necessity. That's why there hasn't been any—at least in proportion to all the time and money spent in pharmacology, pathology, physiology, epidemiology, phenomenology, and some of the other sciences I can't even pronounce. Up to now, all or most of this has been wasted because it was done in a vacuum. Hence the failure of most traditional approaches in the field of rehabilitating addicts. Convincing the various disciplines, professions, and social sciences of the *need* of aftercare seems more important than merely describing *kinds* of aftercare.

There comes a point in an addict's life beyond which aftercare

is both useless and impossible. Such a point is the prison sentence that ceases to be remedial and becomes vindictive. The addict who leaves prison poisoned with hatred and bitterness can't be helped with an aftercare program, no matter how good or expensive it is. The only cure for his poison is heroin. Last summer, while I was living at a large federal prison, I sat and talked with two women inmates. One was there because she had planned to blow up the Statue of Liberty and was caught with more than enough dynamite to do it. The other was caught with not even enough heroin to fit in the eye of a needle. The one with the dynamite was out in five months; the addict still has four years to go.

Motivate the prisoner

The topic of mandatory excessive prison sentences for sick addicts has everything to do with aftercare. Aftercare is useless when someone is too bitter to want it. Why do we have to tell a judge that he is intelligent and experienced enough to impose fitting sentences for every crime but addiction? If he can fit the punishment to the person in other crimes, why can't he in the crimes of a sick addict? The sick addict, sentenced to five or more years in prison with little or no chance of parole, is seldom rehabilitated. If she knew that with effort on her part she could be eligible for parole in a year, then she would more probably and more easily cooperate with in-prison rehabilitation programs. She wouldn't leave prison bitter and resentful against a vindictive society that punishes her with more barbaric cruelty than any other criminal on the books.

So let's do some other kind of research. Let's put fifty addicts in a special prison, give them short sentences and long paroles plan immediate intelligent aftercare and then see how many return to drugs.

Let's research the effectiveness of letting the addict's sentence be determined on the basis of consultation with those entrusted with the responsibility of caring for and rehabilitating him. Who knows best when a sentence ceases to be remedial

nd becomes vindictive—the prison staff, or the legislators in Washington? In other forms of compulsory treatment or psychiatric care, it is the staff that decides on the length of the sentence. Why not at least *research* the same approach with fifty addicts?

Light train to junkville

From the time an addict is arrested, until the day of his discharge from Lexington, he may come in contact with as many as a dozen different departments all the way from the Police Department to the Department of Health. But there is no one department that is charged with the total responsibility of his aftercare. When he steps on that night train for New York City or Chicago, there is no department to pick up and continue whatever good was done in the hospital. I propose that every big city with a drug addiction problem create a special Department of Addict Aftercare. A similar and corresponding department would be set up in every big prison and drug hospital. Contact would be made between the two departments at least one month before an addict's release. During that time, some realistic aftercare plans would have to be worked up before release. This is always one of the most frustrating experiences of my priesthood—riding up to New York City on the train from Lexington, Kentucky, with a half-dozen addicts. They have just received the best medical care in the world from the best doctors. After eating and sleeping well for almost three years, they step on that train looking like executives. But, of course, they don't feel that way. They know when they get off that train at Penn Station, there's nothing to begin with: no home, no job, no money, no worthwhile friends, nothing. On my last trip up, two of the addicts were high before they even reached Washington. I guess they just couldn't face it. Imagine: almost twenty dollars a day for three years, all wasted because there was no department in Lexington charged with the responsibility of working with a similar department in New York City to plan immediate aftercare.

Perhaps this would be easier if every voluntary or sentenced

addict leaving Lexington were at least placed on a mandatory three-month parole. Parole people show some interest in what happens after discharge. They have to; it's their job. Why not give other people the job of planning and supervising aftercare for the unfortunate drug addict, who can't make parole? Why release addicts *with* nothing and *to* nothing? Perhaps all this seems too simple and obvious to deserve any serious attention. But to those of us working with addicts in the community, it is the most important single need in the whole field of rehabilitation.

A sense of humility

One of the memorable remarks of the late President Kennedy to those of us participating in the last White House Conference on Drug Addiction was something to the effect that "a sense of humility is needed to win this war against drug abuse. No discipline or profession has all the answers." I can count on the fingers of one hand the number of times a psychiatrist has picked up a phone and called me for aftercare help before he discharged an addict back into the community. Medical doctors have done it more often, but still not enough.

A challenge to doctors

If the causes of addiction are deep in the roots of the community, then total patient care demands that no doctor or psychiatrist discharge a detoxified addict from a hospital or prison without first asking: "Where will you live tonight? How will you support yourself?" To say, "This is not our responsibility" is like twenty-five people standing by and watching a girl being stabbed to death and doing nothing about it. It is certainly *someone's* responsibility. Why not yours? When I see that medical or psychiatric help is needed to help an addict, I am humble and practical enough to beg it. Medicine and psychiatry should be humble enough to admit their limitations, and then care enough to reach out into the community to seek and demand the aftercare that is needed. The times have been very rare when a prison or hospital doctor or psychiatrist has had the

umility and the common sense to call me and say: "Father
gan, we're discharging a woman who will go right back to
rugs unless someone helps her with a place to live and a job,
nd some supportive help in the community." Whenever the
alls did come, the needs were met. It is because medicine and
sychiatry have not demanded adequate aftercare that rehabili-
ation is such a failure. You doctors and psychiatrists are now
he most powerful and influential force in this field, not the
ederal Bureau of Narcotics. You usually get what you demand.
challenge you to demand immediate intelligent, adequate after-
are facilities for the addicts you want to treat or research.
hen see how quickly federal, state, and city funds will be
rovided.

he Haven filled a need

Every big city needs many different types of aftercare facili-
es. The Village Haven is only one particular type of care. It
rew out of a sense of urgent desperation. A high percentage
f female addicts have no place to live after hospital or prison
elease. In recent years it has become easier for addicts to get
n welfare—easier than it used to be, not easier than it is for
on-addicts—but only the poorest apartments in the poorest
reas could be rented on a welfare cheque. These were usually
rug areas, so that wasn't the answer. Of course, a better apart-
ment in a better area would help, but rent that high demanded
rostitution, and before they can prostitute, many addicts must
rst drug their consciences (not their bodily feelings) with
eroin. So the rat-race began again. For the female addict who
ried to make it without welfare or prostitution, it was an easy
matter to buy her a legitimate job from a legitimate employment
gency and then give her enough hotel rent to last until pay
ay. But somehow, very few seemed to make it to pay day.
loneliness is a cause of addiction. To return each night to a
nely apartment and just look at four walls was an excuse to
eturn to drugs. Furthermore, the drug addict with a record,
iving alone, can easily be arrested. And she is presumed guilty

until proven innocent. But how can *she* prove she's innocent? She can't! Just look at her appearance; just look at her record—and so "The Haven" grew out of an urgent necessity.

The Village Haven is a four-storey brick building in Lower Manhattan. In addition to thirty-six bedrooms, it has a large living room, dining room and kitchen, a medical clinic, craft rooms and classrooms. Any female addict may live at the Village Haven, fresh out of prison or hospital, so long as she is free of drugs, willing to live by the rules of the house, and presents no problem of physical fighting or overt sexual aggressiveness. Because it is in the heart of New York City and is not a prison, it runs the risk any program runs that tries to help weak human beings in the community. It is 99 per cent drug-free, which can't be said of some prisons. Its rehabilitation success rate is higher than that of any prison. Over 60 per cent of all girls who have lived at the Haven for at least two weeks are now drug-free. Its program has been in operation for only a little more than a year and a half. So, understandably, its directors and staff are not yet satisfied with its dynamics. We are in the process of learning. But the New York City Department of Mental Hygiene has been so encouraged by what they have seen that our Village Haven Halfway House for female addicts has recently received a grant of \$90,000 to structure its program better. Nine rooms on the top floor, next to the clinic, are occupied by pregnant addicts in an attempt to research the best way to help the addict mother and her addicted baby.

Less than half the cost

More such Halfway Houses are desperately needed in every big city. The cost to taxpayers of keeping an addict at a Halfway House is less than half the cost of prison and a quarter of the cost of a hospital; yet it could do fifty times more good, more quickly and more effectively. Properly structured, such houses could supply all the needs of aftercare. Since there are no absolute, reliable, scientific facts to contradict me, I would venture the opinion that 80 per cent of all addicts leaving prison

hospitals are neither psychotic, nor psychopathic, nor even dangerous neurotics. Neither are they as stupid as some addicts like to call each other. They are just plain "ignorant." They're smart enough to support an average \$10,000-a-year drug habit, but they're not smart enough to fit into and survive in a conventional society—they never learned how. So they are "sociopaths." Fresh out of prison, they need a place to live, food and clothing, and cigarettes. They need on-the-spot counselling, preparation for a job and help in getting one. They need contact with straight people to learn straight living. All this can be provided within the four walls of the Halfway House. This is what aftercare means.

Reality therapy at Daytop

Perhaps the most exciting and hopeful development in this field of rehabilitation is New York City's Daytop. It stands a bit off centre between Synanon and Lexington. Synanon has begun aggressively independent. It has been openly and proudly anti-professional. It has defied most attempts to research and evaluate its claims. But those of us who believe what we see cheer for the miracles daily repeated at Synanon. On the other hand, those of us who appreciate Lexington the most are understandably its most outspoken critics. Its totally conservative and rigidly traditional approach has produced many worthwhile statistics, and has detoxified hundreds of thousands of addicts. What has been learned from all this is invaluable. But along comes Daytop, draws the best from both, discards what is useless or harmful, and develops its own vigorous dynamic of self-help treatment aimed at re-education and total personal growth. Staffed by ex-addicts, under a medical-psychiatric superintendent, Daytop has added a research design that permits evaluation and transmission of its "reality therapy" to all who need it. Any city or group interested in developing a Halfway House for addicts could do nothing better than draw on the experience and training of a Daytop graduate.

Looking back over the years, I recall how many, many times

two or three years of normal drug-free living could have been saved if only there had been some way of an addict's getting methadone in a legal, medical environment at the right time. Aftercare must begin with the presumption that even though it is not inevitable for an addict to return to drugs, there is some degree of probability that he might. If, as often happens, an addict is working well for two years, free of drugs, faithful at work, supporting his wife and children, and all of a sudden because of some unexplainable sudden compulsion takes his first fix in years, why must all this be lost? Often, with equal suddenness, the reality of what he is doing hits an addict only two weeks later. Then, in fright he says: "Like, man! What am I doing?" By now he's taking a fix a day at five dollars a bag. He knows from experience that this can't go on; that in a few days he will need more junk and more money, and that his job can't support both a habit and his family. He doesn't want to lose everything it took him two years to gain. He really wants to kick this cheap little habit before it *really* hooks him. Yet he knows that he can't do it alone and keep his job. At such a moment it would save many an addict and his family if he could easily be referred to a medical clinic by an approved aftercare agency, and given small reducing doses of methadone pills to take him off his two-week habit. He could thus save himself his job, his family, and two years of good living, on a few cents a day of legal medication. No, he doesn't want to *stay* on methadone—he just wants enough for a week.

There are valid objections to such a clinic, but so are there valid objections against every other solution to the problem. I can think of any thorough aftercare program that wouldn't include this type of medical clinic for such an understandable and foreseeable eventuality. Up to now the other solutions have only perpetuated the problem.

Psychiatry outside the prison

Every big city with a drug-addict problem has a large population of addicts in city prisons. If psychiatry is the answer to

their problems, then why is there not more psychiatric care in prisons? In cases where more of such care is doing good, it is a tragic waste of effort not to continue that care after release. I propose the establishment of a specific type of out-patient psychiatric clinic located as close as possible to every city prison where addicts are incarcerated. This way the prison psychiatrists can easily continue the help that was started in prison. This way the relationship, confidence, and trust that the addict developed in his psychiatrist isn't suddenly broken when it is needed most. The psychiatrists and their staff of psychiatric social workers could divide their time equally, spending half of it in prison and half at the clinic. All too often, when an addict is re-arrested and returns to prison, he uses the excuse that he couldn't reach the other psychiatrist he was referred to, or that he didn't like him. It's difficult to decide if this excuse is valid or not. Often in prison it is a difficult and expensive waste of time to decide who really needs and wants psychiatric help and who doesn't. Their sincerity could be tested and proven by their willingness to continue the treatment after release. How often I've brought a woman back to the prison and pleaded with her psychiatrist just to calm her for ten minutes. The patient wanted his help; he wanted to give it; but cold, impersonal, unrealistic, outmoded rules forbade it. Perhaps a ten-minute conversation with her psychiatrist at that moment might have kept her off drugs for another six months.

Help around the clock

This type of out-patient clinic I recommend would have a twenty-four-hour answering service with a well-oriented staff working around the clock as a team. If society can arrest or catch an addict at any hour of the day or night, why can't society help him at any hour of the day or night? Each person's needs would be met when and as they were needed, be it psychotherapy, tranquilizers or a temporary maintenance drug. This kind of aftercare would fill a real need. It has never been researched. It is a type of addict aftercare that could prevent

much crime, many arrests and many repeated incarceration.

Most addicts have no urgent need for psychiatric help. All the need is a job. There is, then, a desperate need for a special kind of employment agency—one geared to help addicts find work. Many addicts are unemployable. Others aren't trained to work at any specific job, but could do many jobs well. If we can afford twenty-five dollars a day to detoxify an addict, why not pay him that amount to get him a job? Take drugs away from an addict and what is there to fill the void? So he has to work to survive. How many female addicts over the years have described to me "how good it is to go to bed at night, sleepy from hard work and not from a handful of pills." The good contented feeling of earning sixty-five dollars a week in a factory and not twice that amount in one night in prostitution. "But it's clean money, Father, it ain't dirty!"

Job training, but no jobs

The Village Haven was once a dream. Now it's a happy working reality. I have another dream these days, which I pray God will soon come true. Every day many fine expert seamstresses are discharged from female prisons. They're really good at their work. They learn it from experienced teachers in prison. They practice it daily for years behind the walls. When they leave, the talent leaves with them, but it can't be used because having a drug record and just having been in prison is an almost insurmountable impediment to getting a job.

If I had a grant of \$200,000, I would buy a four-storey building not far from the Women's House of Detention. I would furnish the two top floors with living quarters for about twenty-five girls who had training in sewing and tailoring. I would renovate the second floor into a few large rooms equipped with all the machinery needed for these girls to cut, sew, fashion and tailor women's clothing. On the first floor, the girls would display and sell what they produce. It would be a halfway house like no other halfway house. When a girl graduated to go out on her own she could get a letter of recommendation from a genuine

business establishment instead of a prison. It offers so many possibilities for aftercare, the wonder is that it doesn't already exist. Services like this, however, seldom get a federal grant of money, because approval seems to depend on whether or not the service has a staff of psychiatrists and research men. Unfortunately, this kind of aftercare service would only need a building, sewing machines, a few experienced sewing instructors who cared about female addicts, and frequent advice from people in the garment industry.

At the ex-addict involved

The ultimate success story in every addict's life is to see him living and enjoying a conventional life, but very much involved in the community war against drug addiction. With most addicts well known, who have been clean for a number of months, there seems to be a definite sense of compulsion to help others, or to share their new life with others. It's almost like a form of prostitution. Rather than try to explain it, let's use it. In spite of the hazards, one of the most successful forms of aftercare for these addicts is to get them quickly involved in caring for other addicts. They, more than professionals, are the best people to operate two badly needed aftercare services:

(1) **Store Fronts.** Deep in the jungles of "junk land," there are some addicts who need only the right motivation to attempt to go back to society. A clean addict is the one to give this. A clean addict is the right one to give hour-by-hour encouragement to another clean addict who is finding the road back long and difficult. I would urge that clean addicts staff and operate many of these beach-heads deep in city junk lands.

(2) **Round-the-clock Phone Service.** A few weeks ago, I asked a clean addict what one kind of aftercare service was most urgently needed and that he would like to operate. He was off drugs more than five years, a graduate of Synanon in California and now one of the assistant directors of Daytop. I waited for something elaborate and profound. Instead, he said with conviction: "I'd run a twenty-four-hour phone service." All of us

deeply involved in aftercare know the miracle of the human voice, when it expresses hope and concern and love to a soul in need. I could never begin to remember all the addicts I have kept off drugs for another day, another week, another month, just by being there when they phoned. When a clean addict loses a job, is refused welfare, or just needs reassurance or advice, there's no therapy more helpful than a phone call. Help is as close as the phone—not a fix. Yet no one is more capable of giving better advice or understanding to an addict than another addict. This would be a relatively inexpensive aftercare service, yet its good could never be measured in dollars and cents.

Don't knock the non-professional

Since all the traditional, professional approaches to rehabilitation have failed, it seems urgent that without any further waste of time or wounded pride, we take an honest, long, hard look at ourselves, and decide if the professionals alone really have the answer. Once the technical aspects of research have helped an addict withdraw from drugs with medical care, then what can a professional do for the addict that a non-professional can't do equally well, or maybe better?—at least, in those humane aspects of aftercare that are so urgently needed in gradually integrating the addict back into the community. I include myself in this criticism, because I'm as much a professional in this field as a doctor, psychiatrist, psychologist, pharmacologist, or sociologist. Drug addiction, at its root causes, is more of a spiritual problem than anything else. I'm a professional in spiritual problems. Time after time, when my spiritual professionalism failed to keep a person off drugs, it was a simple happy housewife and mother who did. Aftercare is really a person-to-person relationship, not an agency-to-addict interview. We professionals should not be so jealous of our training and status that we can't see our limitations. This war against addiction is too big for any one discipline or profession. As a non-professional said at the World House Conference: "There are too many chiefs and not enough Indians." We have failed to rehabilitate because we haven't sought

encouraged the assistance of dedicated people in the community. All they need is a little wise direction and the conviction we need and appreciate their help. Let's be humble enough to admit our failures and ask their help.

addiction and guilt

Let me mention spiritual assistance last, not because it is least important but because man's spiritual end gives meaning and purpose to all else. Good psychiatry begins with the problem of how a particular addict can live his life most happily in a community. Psychiatry runs head-on into two concepts that can't be properly understood without theology: the meaning of life and the meaning of happiness. Where psychiatry ends, religion begins. An observant psychiatrist in the field of drug addiction runs into a conflict with that awful word "guilt." He may coin another word for it, but it's still there. He may remove the neurotic part, but not the real. And no amount of tranquilizers, shock therapy or psychotherapy will take away sins against God. The law may pardon, but only God can forgive. Addiction and guilt; addiction and aimless living; addiction and pleasure seeking; addiction and life without God: these terms are so synonymous, it is surprising that theology has been kept out of this field for so long.

the clergy in

When has the National Institute of Mental Health ever demanded as a condition for a grant of money, that an addiction rehabilitation agency structure its program to include spiritual dynamics? This sounds revolutionary, but maybe only something revolutionary will bring success into a field that is littered with human failures. In most hospitals and prisons that deal with addicts, the rabbi, minister or priest isn't *part* of the staff. We are never asked to sit around a table with you to discuss the best way to help a human person find life's true meaning and purpose. At most, we are tolerated; and see what little good you have done without us. I can show you five successes for each failure when

we worked together. And for every five successes we have achieved together, I can show you thousands of failures where you tried to rehabilitate a soul without our help.

The assumption that psychiatry offers the most successful and the most scientific treatment in the rehabilitation of addicts based more on faith than on demonstrable proof. There is absolutely no evidence to support the alleged superiority of the psychiatric approach over other available approaches. But there is every evidence that psychiatry working *with* pharmacology, medicine, sociology and *theology* is more successful. If recidivism is taken as a criterion, then the psychiatric approach to rehabilitation has been a failure.

Any evening on my knees in prayer, I can count off on every bead of my Rosary, a clean addict who is off drugs tonight because psychiatry and medicine had enough humility to ask for two things: spiritual assistance and immediate, continued after care.

So let's work together as a team. It's too, too big for any one profession. Remember, you'll continue to fail and fail without my kind of help. You have, up to now.

Comment

By S. J. Holmes, M.D., D.Psych.

Father Egan has given us a very well-rounded, simply stated common-sense plan for an approach to drug addiction in the community. We would do well to heed his advice, which is based on years of experience with many addicts. It is indeed time that we researched the strengths of the various approaches to the rehabilitation of the drug addict that are now available in our country and the methods of integrating the strengths of each, and it is time we stopped the present waste of time, energy and tax dollars on un-coordinated programs that have only

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limited effect; most of all, it is time we stopped the waste of potentially useful human lives.

Over the last fifty years, our program for the control of drug addiction has fluctuated from strictly legal and punitive approaches, with their obvious limitations, to highly involved scientific explorations of the problem—also with obvious limitations. It appears that the need to become ultra-scientific has been a tactic to engage and out-manoeuvre the legal attitudes, which had become so entrenched, with their air of accuracy, appropriateness and efficiency, and which regarded drug addiction simply as a scourge and a blight.

On the scientific side, ultra-authoritative approaches attract impersonal, ultra-authoritative types of people; they also attract dogooding types who have a bias—overt, concealed or even unconscious—against constituted authority. It appears that the ultra-scientific group in general may have used scientific jargon to out-manoeuvre and bamboozle the authorities—to blind them with science, in fact.

In the midst of the seesaw struggle of the legal and scientific factions, the drug addict has been pulled and twisted into a very unreal person. Basically, as we all know, the addict *is* a real person, and much can be done with him by simply accepting him as such—giving him the dignity he deserves, which he has been denied for so long during his banishment to the tenderloin areas of the cities and to the reformatories and prisons of organized society. Accepting the addict as a real person does not, of course, mean accepting his self-destructive way of life—contrary to what many people seem to think we mean by acceptance.

common-sense suggestion

Father Egan's proposals are based on the simple idea that ordinary people—non-professionals—can sometimes help other ordinary people; his common-sense suggestion is that people who have been on the addiction treadmill and have succeeded in getting off it are better able to help others get off it than are people who have never been on it. His suggestion is that, at the

very least, former addicts merit a place in the treatment scene and on the treatment team.

In Canada at the present time there is an array of varied programs in the drug addiction field, from those of the penal system, organized under the Narcotic Control Act and the Food and Drug Act, to those of the community organizations. Unfortunately, there is very little communication between these programs, and therefore there is very little development and coordination in aftercare. Our experience to date at the Addiction Research Foundation in Toronto has shown a crying need for integration of these services and for the development of a twenty-four-hour, seven-day program along the lines that Father Egan suggests.

Do helpers fight over addicts?

At the present time there are fragments of this type of organization, which, if they could be welded together with a common purpose, could do much more than any of them are doing singly—almost competitively—at the present time. To do this, there must be a motivation towards rehabilitation of the addict in society on the part of the helping people—whether they be medical, sociological or legal in their orientation—so that they may arrive at a common goal, utilizing their strengths and not preying on each other's weaknesses in pursuit of publicity, status or grant gains. Their sole goal should be the fundamental purpose of accepting the addict as a human being and offering what services and skills they may have for his rehabilitation.

This means putting away the professional jealousies that often come with an academic education and with the differences of status that may be conferred by various academic backgrounds. It means incorporating the stabilized addict in the treatment team and accepting the fact that the knowledge, understanding and skills he has acquired in the field of addiction are just as much a professional need in the helping area as a university degree.

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FALL, 1967

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ADDICTIONS is published four times a year by the Addiction Research Foundation, an agency of the Province of Ontario.

The contents of each issue are selected on the basis of their potential interest to persons engaged in research, treatment or education in the field of alcoholism and drug addiction.

Articles published in ADDICTIONS do not necessarily reflect the view of the Foundation.

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Addiction Research Foundation,
Education Division,
344 Bloor Street West,
Toronto 4,
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Editor: Alasdair McCrimmon



Authorized as second class mail by
the Post Office Department, Ottawa
and for payment of postage in cash

A.I.T. Addictions

Volume 14, Number 3

Fall, 1967

Abstinence Criteria in Alcoholism Treatment

By E. Mansell Pattison, M.D.

As the scientific study of alcohol problems has developed in recent years, a number of untested and unquestioned assumptions about alcoholism have been challenged by clinical and research evidence. Two such assumptions are that total abstinence is necessary during treatment, and that total abstinence is the criterion of successful treatment. In this paper I shall explore the bases for these two assumptions, review relevant recent research, and summarize our current research in Cincinnati, which suggests that the abstinence criteria require re-evaluation and modification.

The reasons why

Assumptions do not arise *de novo*, nor are they retained unless there are some reasonably compelling forces. And if we are to question widely-held assumptions, we must also recognize and

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speak to the reasons why they are held. The assumptions about abstinence seem to stem from five sources:

I. Cultural Ambivalence

It is an interesting paradox that the United States, which has one of the highest national rates of alcohol consumption also has marked cultural ambivalence about alcohol. Numerous social scientists have indicated the etiological influence of this ambivalence in producing the high incidence of alcohol problems in the United States.^{29, 48, 71} Our national cultural ambivalence is acted out by society accepting and desiring the pleasure of alcohol on the one hand; but on the other hand there is general cultural guilt about such drinking, which reinforces the hostile side of the ambivalence and is expressed in the continued cultural rejection of the alcoholic and the demand that he pay for his sins by remaining abstinent.^{23, 40} Szasz⁶⁹ has described this as a cultural counterphobic mechanism, while Moore⁴⁵ has described it in therapy as a reaction formation.

My argument is that there is evidence for a cultural need to maintain the abstinence assumption as a means of handling this cultural ambivalence. Indeed, Lolli,⁴¹ Chafetz¹⁰ and others^{9, 11, 13, 16, 25} have suggested that it is time to begin to pay attention to our cultural attitudes about alcoholism if we are going to make significant strides in research and in the prevention of alcoholism. So long as there is personal and cultural ambivalence about alcohol, there will be strong cultural forces maintaining these abstinence assumptions.

II. Institutionalized Needs

Under this heading I refer to the fact that alcoholism was for a long time solely the concern of alcoholics themselves and scientists have really been (and still are) johnny-come-lately. The invaluable impetus of Alcoholics Anonymous is too familiar to require discussion.

However, as Pittman and Snyder⁵⁸ have recently pointed out, the social psychology of Alcoholics Anonymous and the

fluence of other ex-alcoholics working in the field of alcoholism is only beginning to be examined.³⁶ Boyes,⁶ discussing a paper on the therapeutic values of Alcoholics Anonymous, has noted that almost no attention had been given to the opposite dysfunctional aspects of AA's social structure. However, the influence of these dysfunctional aspects has been reported in recent papers.^{30, 33, 55, 64, 65}

In his polemic critique of Alcoholics Anonymous, Arthur Cain⁹ asserted that AA and other ex-alcoholics had perpetuated abstinence as a myth. Cain's criticism seems plausible on the basis of the sociological evidence. However, he fails to take account of the *socio-psychological necessity* for the maintenance of the abstinence assumption.

Why AA works

Here, the recent book *The Social Psychology of Social Movements*, by Hans Toch,⁷² is most relevant. Toch points out that Alcoholics Anonymous (and many other self-change social movements) are effective because of three assumptions:

1. That a social movement can solve the person's problem.
 2. That the specific movement in question can solve the problem.
 3. That the specific techniques of the movement are the best and only techniques that can accomplish the job.
- Most significantly, Toch notes that "the assumption that the movement's techniques are the best is usually false, [but] it is a useful assumption."

From this I would argue that Alcoholics Anonymous (including many ex-alcoholics not necessarily involved in AA) *must* maintain the abstinence assumption as an institutionalized policy if it is to retain its therapeutic effectiveness as a social movement. Thus, rather than criticizing AA and other ex-alcoholics for maintaining the abstinence assumption, the evidence suggests the importance of their retaining these assumptions as one of the necessary beliefs of an effective self-change social movement. Likewise, it is necessary for many alcoholics to

believe in and practise abstinence. However, the reality of these institutional and personal needs cannot be construed as a general principle for all alcoholics.

III. Simplistic Causal Concepts of Disease

The medical model of disease, and of science in general has traditionally been based on the concept of parsimony. That is, it was assumed that a cause-and-effect theory involving only one factor was more desirable than a theory invoking several factors. Translated into therapy, treatment process was assumed to be a single factor, and treatment outcome had only one dimension. But it is now obvious that any treatment process involves many specific and non-specific variables and that any treatment is "successful" if the patient is abstinent. However convenient this model may be, it does not do justice to the data.

IV. Concepts of Addiction

The primary concern in the treatment of alcoholism has been for the so-called addictive alcoholic. The commonly held concept of addiction is based on the development of physiological tolerance for a drug, withdrawal symptoms, and physiological and psychological dependence on a drug. This concept of addiction is a pharmacological one, giving rise to the assumption that once addicted, the addict is saddled with *irreversible* pharmacological and physiological changes. Hence, an addict must maintain abstinence.

All this is based on a *particular concept* of addiction; but this concept has been seriously questioned by both basic scientists and clinicians.^{27, 34, 50, 61} For example, in a recent review Freedman and Wilson¹⁹ note that no experimentally verifiable concept has emerged clarifying the mechanism of tolerance, or relating this to physical dependence or addiction. They conclude: "The most significant characteristic of addiction is the qualification of *harm* to oneself or to others produced by the regular or habitual use of any substance. The production of

physical dependence, with its concomitants of tolerance and withdrawal symptoms, is often, but not necessarily, present."

Numerous clinicians have observed that narcotic addicts vary in their pattern and degree of addiction.^{7, 12} Some use narcotics in an addictive fashion for a period, but later use the same narcotic in a non-addictive fashion. The same observations have been made on alcoholics. Not all addictive alcoholics always drink in an uncontrolled fashion. Indeed at times they drink in a fashion that superficially might be considered normal.^{28, 52, 53, 54}

Keller's definition

These facts have been recognized in Keller's³¹ monograph in alcohol language, in which he defines alcohol addiction as characterized by an overwhelming desire, need, impulse or compulsion to drink . . . marked by a tendency to be unable to stop drinking when drinking is begun." Keller then distinguishes alcohol addiction from drug addiction, in which there is, in addition, a tendency to increase the dose, and in which physiological dependence is much more probable. However, the evidence indicates that narcotic addiction and alcohol addiction are not so dissimilar, but rather that the whole concept of addiction requires re-evaluation.

A way of living

Addiction cannot be pursued in depth here, but the evidence is mounting that the observed *phenomenon of addictive behaviour* is not identical with or dependent upon phenomena of pharmacological or physiological dependence, tolerance and withdrawal symptoms.^{2, 12, 30, 33} Rather, it suggests that the concept of addiction is a *psychosocial behaviour syndrome*—involving physiological factors, but not as the primary determinants of addiction.^{2, 12, 30, 33} (Cf. the concept of "social addicts" by Brotman *et al.*⁷) Indeed, addiction appears better conceptualized as behaviour based on the use of drugs as the central integrative symbol around which the person organizes his life.

If this be so, there is good reason to assume that *a person who has changed his pattern of living* could use, without harm a drug to which he had previously been "addicted."

V. Clinical Experience

Perhaps the most obvious support for the assumption of abstinence has been the countless personal and clinical observations of futile and destructive attempts by alcoholics to return to drinking. Are we to discount this? Obviously not; however, several points are worth making.

The observations by members of Alcoholics Anonymous represent a highly biased sample, unrepresentative of the total population of alcoholics.⁶⁴ The same can be said for most professional treatment centres: the clinician rarely sees the alcoholic who did not stop drinking during treatment, or who returned to normal drinking; he usually only sees those who have had difficulties. In our own recent research we have found that almost all of our now-normal drinkers were highly suspicious of our follow-up procedures, would never have returned to a clinic for an interview, and would never have filled out a follow-up questionnaire.⁵⁶ Follow-up studies that have pursued ex-patients into their homes have regularly reported a certain incidence of normal drinkers, but follow-up studies relying on voluntary return to the clinic have rarely found such normal drinkers in their sample.⁵²

Thus, the clinical experience of workers in the field of alcoholism supports the assumption of abstinence, but their experience represents a biased sample. The extent of that bias is yet unknown.

Another clinical argument has been that effective treatment programs would be impossible without maintaining such assumptions. However, I have personally directed an alcoholism clinic without rigidly hewing to these assumptions, and have had personal communications with a number of other clinic directors who have reported similar experience. Whether or not to maintain the abstinence assumptions is *not* the question.

be asked. Rather, I suggest that the clinical question is how, when, and where to apply the abstinence assumptions in a clinically useful manner.

A final clinical argument has been that alcoholics would be encouraged to continue to try to keep on drinking. In my own personal experience I have had alcoholics and their families write or phone me saying that they had heard or read my discussions of these issues and then tried to drink, followed by disastrous results. Although one deeply regrets these reactions, it must be pointed out that they are the result of misinterpretation. Neither I, nor any other author of whom I am aware, have recommended that alcoholics should try to continue drinking. Actually, every author has taken pains to point out that alcoholics must learn how to live without alcohol. Further, each of these unfortunate incidents is another example of the self-defeating attempts of the alcoholic to find excuses to justify his drinking and rationalize his behaviour in the face of evidence demonstrating the destructiveness of his alcoholic life.

Recent evidence

In my recent extensive review⁵² I have elaborated the evidence at length. Here I shall only briefly summarize research that indicates:

1. That a certain proportion of addictive alcoholics do return to normal drinking.
2. That abstinence subsequent to therapy may not be related to improvement in overall life adjustment, and may even result in deterioration.
3. That abstinence is not necessarily a requisite for the conduct of successful therapy or rehabilitation.

In regard to the first statement, in 1962 Davies¹⁴ gave a detailed report on 8 of 93 addictive alcoholics who had returned to normal drinking after a period of abstinence. Fox and Smith¹⁸ compared first- and second-year follow-ups and reported that 24 per cent of the total group had improved in the second year and were drinking to some extent. Moore and

Ramseur⁴⁷ found that 5 of 14 most improved patients were well-controlled social drinkers, whereas 6 of 15 abstinent patients were only slightly improved. Norvig and Nielsen⁴⁸ reported that 74 per cent of 57 patients with temporary indulgence were doing well. Pfeffer and Berger⁵⁷ found that 7 of 60 patients had changed their pattern of drinking to normal drinking and that 3 of the 7 were free of psychological symptoms. Selzer and Holloway⁶⁵ reported that 16 per cent of 83 patients had returned to successful social drinking. Lemere³⁸ found that 3 per cent of problem drinkers returned to normal drinking, and Shea⁶⁶ reported a psychoanalytic case where an addictive alcoholic returned to normal drinking. Lambert³⁷ found 25 of 100 alcoholic patients who claimed the ability to drink in moderation, although he felt that only 9 were able to truly drink moderately. Robson *et al*⁶² stated after a large follow-up study that "a surprisingly large number seemed to have managed to control their drinking . . . while not completely abstaining." In a group of 62 *untreated* alcoholics Kendell¹ reported 3 men and 1 woman who had resumed normal social drinking for three to eight years. From a visit to Japan Lemere³⁹ reports a treatment plan by Dr. H. Mukasa, who gives alcoholics a small daily dose of cyanamide—which allows the alcoholic to take one or two drinks, although he will become ill if he drinks more. Thus these alcoholics are treated successfully as continued moderate drinkers. Hacquart *et al*²⁴ reported that 18 of 100 patients returned to moderate drinking after disulfiram therapy. Bailey and Stewart¹ reinterviewed 12 who had returned to normal drinking. This was 7 per cent of an original sample of 91 active alcoholism cases. Cain⁹ reported that 4 of 7 successfully treated alcoholics and over half of 20 other cases had recovered the ability to drink in normal fashion; however, he does not give any case details. And finally, a highly relevant report was published in the French literature back in 1952. De Morsier and Feldman¹⁵ prospectively followed 500 cases where they made a distinction between social cures and abstinence cures. Seventy-six of 500, or 15 per cent

ere social cures, while 155 of 500, or 31 per cent, were
stinence cures. They comment that the social cures were
noticeably superior in their adjustment, that these people did
not want to present themselves socially as complete abstainers
and so learned to avoid the psychological bad effects of alco-
hol, and that drinking was now done in a family and social
context only.

These reports were essentially clinical follow-up studies;
however, their weight does support the conclusion that a
certain number of alcoholics do return to normal drinking
with good life adjustment, often superior to that of those who
are abstinent.

Abstinence without improvement

In regard to the second statement, Bolman⁵ has observed
that abstinence may not logically or clinically indicate an im-
provement in overall health or life adjustment. In 1962 Gerard,
Senger and Wile²¹ reported a study of "successfully" treated
abstinent alcoholics. They found 43 per cent overtly disturbed,
14 per cent inconspicuously inadequate, 12 per cent Alcoholics
Anonymous "addicts" and only 10 per cent independently
making a successful adjustment. Moore and Ramseur⁴⁷ reported
that 6 of 15 abstinent patients were only slightly improved.
Wilby and Jones⁷⁵ found that over-all improvement *declined* in
a group of abstinent patients assessed at eighteen- and twenty-
four-month intervals. Pfeffer and Berger⁵⁷ found that 30 per
cent of their abstinent patients still had significant psychologi-
cal symptoms and life difficulties. Flaherty, McGuire and
Katski,¹⁷ and Wellman,⁷⁴ have described the symptoms of de-
pression and anxiety that may occur many months after remain-
ing abstinent. And Wallerstein⁷³ has noted that enforced sobriety
can be disastrous to personality integration—particularly when
alcohol is the mechanism by which borderline characters or
psychotic personality structures maintain ego integration, dim-
inish hallucinations, or allay overwhelming anxiety.

Improvement in drinking behaviour is not necessarily related

to improvement in social, vocational or psychological adjustment.²² Thomas *et al*⁷⁰ found that drinking behaviour did not correlate with three other areas of life adaptation. Brunn⁶ defined being cured as either abstinent or engaging in non-deviant drinking; he defined being changed as social or psychological changes in the personality. He suggested that drinking variables be considered apart from other variables of improvement. Mindlin⁴⁴ found a high correlation between drinking and other parameters of health, although they did not parallel current drinking. Blane *et al*⁴ have found that covert types of alcoholics display few dysfunctional social or psychological problems even though they have severe drinking problems. The World Health Organization definition of alcoholism in terms of the drug effect on social and psychological functioning unfortunately tends to fuse these parameters.⁶³ Clinically it seems wiser to consider drinking deviance apart from general adaptations in social, vocational and psychological areas and in physical health.

No arbitrary rules

In regard to the third statement, no necessary relationship between abstinence and the successful conduct of therapy has been demonstrated. Moore⁴⁶ and Krystal³⁵ have discussed this issue at length, and both conclude that the prescription of abstinence during therapy must depend upon the understanding of the role of alcoholism in a given patient's life rather than upon arbitrary rules. Bolman⁵ has recently reviewed this entire area, concluding that there are many differences of opinion regarding the importance of requiring abstinence as a necessary condition of psychotherapy, and that there are also corresponding differences regarding the nature of the relationship that exists between abstinence and clinical improvement.

Because the previously cited studies were based on clinical observations, we developed a research study to test the hypothesis that successfully treated alcoholics who engage in no pathological drinking were as healthy mentally, socially, voc

onally and physically as abstinent alcoholics. This study has been reported in detail elsewhere,⁵⁶ so it will be summarized here in terms of the relevant findings.

The sample was drawn from all male patients who were discharged as improved during a one-year period and who had been seen in the Cincinnati Alcoholism Clinic for ten or more visits. Patients were not included who were discharged from treatment less than one year prior to the follow-up study, because several reports indicate that the probability for loss of abstinence is highest during the first six months after discharge,²⁰ and that adjustment remains stabilized after the first year. The sample consisted of 32 male ex-patients who met all these criteria.

Using a modification of an alcoholism follow-up schedule developed and standardized by Gerard, Saenger and Wile,²¹ scales were constructed to assess physical health, interpersonal health and vocational health. Mental health was assessed using the total score on the *Spitzer Mental Status Schedule*.⁶⁷ A drinking scale score was devised to reflect drinking quantity, behaviour and sequelae. A normal drinking score could only be achieved by a person whose drinking was less than once a week, without episodes of intoxication, without experiencing a compulsion to continue drinking, and without psychological, physical or social sequelae to his drinking.

Interviewed at home

Two independent judges reviewed each admission record and rated each patient for health and drinking behaviour prior to treatment. Then each ex-patient was located and interviewed at his own home by a psychiatrist, expert in the field of alcoholism.

Prior to treatment, the group was homogeneous on ratings of overall health and severity of alcoholism. All were overtly addictive alcoholics. All had been discharged as improved. At follow-up, the drinking scale ratings and the ex-patients' self-ratings split the sample roughly in thirds: eleven abstinent,

eleven normal drinkers, and ten pathological drinkers. The interviewer, however, only rated eight as normal drinkers. The three groups did not vary at follow-up on physical health; but in vocational, interpersonal and mental health, the abstinent and normal drinkers did not differ between themselves and were relatively more improved than the pathological drinkers. The same relations were observed whether the self-rating, the interview rating or the drinking scale scores were used to define drinking status.

Implications

What are the implications from this re-evaluation of the abstinence assumptions?

I. It shows that the assumptions of abstinence need not be abandoned; they serve certain useful cultural, institutional and therapeutic purposes, and these are cogent reasons for retaining them in modified forms. However, the need is just as compelling to re-evaluate our assumptions of abstinence so that they do not constrict or subvert our research, therapeutic and educational efforts.

II. It provides evidence for the necessity of a revised concept of addiction. One hypothesis for the observed phenomenon of return to normal drinking may be in terms of psychosocial equilibrium. Assuming that addictive drinking results from a combination of cultural, social and intrapsychic vectors, manipulation of these vector relationships may prove remedial. Hence a man with a cultural "press," an appropriate character structure, and a specific social context may remain an addictive alcoholic only so long as this particular combination of factors obtains. If one shifts these vectors, changing the cultural milieu, the personality structure, or the social interaction, the gestalt necessary to perpetuate the addictive drinking may be eliminated.⁵¹ Chein *et al*¹² conclude in regard to addictive behavior that "such behavior is not random but shows a remarkable precision of aim and aptness to life situations and relationships."

The concept of addiction as a psychosocial behaviour

ndrome has been colourfully described by Eric Berne³ as the
ame of "Alcoholic": "The criterion of a true 'game cure'
that the former Alcoholic should be able to drink socially
ithout putting himself in jeopardy. The usual 'total abstinence'
are will not satisfy the game analyst." Berne goes on to point
ut that the same alcoholism game can continue as "Dry
lcoholic." This same direction of thinking is also found in
ain's book, *The Cured Alcoholic*,⁹ which, though written in
n argumentative fashion, does contain some very important
ocial and psychological insight. Cain notes that the *recovered*
coholic does not drink primarily because he does not *want*
o drink, whereas the *arrested* alcoholic still has the desire
o drink but knows that he cannot and tries to avoid doing so.
ain states: "The recovered alcoholic, by definition, does not
are whether he can drink normally, and he definitely does
ot want to become intoxicated again." Cain goes on to point
ut that *most alcoholics do not want to return to normal*
inking; by normal drinking they mean the intoxication they
ere once able to control, which is nothing like our definition
f normal drinking; the arrested alcoholic never really loses his
esire to become intoxicated with alcohol. He learns to control
is desire—that is, he learns to live with his disease—but he
ever learns to transcend his desire. Cain suggests that such
rrested alcoholics could never return to normal drinking,
ecause their pattern of life still revolves around alcohol even
ough they do not drink. Cain then states significantly: "The
act that normal drinking has been achieved is a dramatic
ndication of one's successful effort to attain social, intellectual
nd religious maturity." This same concept is found in the
bservation of "maturing out" of narcotic addiction.⁷⁶

n technical terms

What Cain describes in a popularized fashion has been argued
n more technical psychological and sociological terms in sev-
eral books and articles.^{2, 13, 25, 30, 33} Using symbolic interactional
neory or game models, they make a clear case for addiction

in terms of the drug symbol with more relevant effective symbols for governing life interactions. If this be the case, then the addictive alcoholic can return to normal drinking—but only if his pattern and motivation for living has been re-integrated around healthy symbols, and alcohol is no longer a central symbol of his life. The alcoholic who would like to return to normal drinking cannot; the alcoholic who no longer cares if he ever drinks probably can.

III. Return to normal drinking appears to occur in a significant proportion of treated alcoholics. The characteristics of these alcoholics remain to be determined, as well as the reasons for this type of outcome. We have no reliable estimate of the incidence of the phenomenon of return to normal drinking among either treated or untreated alcoholics, or under various conditions of treatment.

IV. Improvement in drinking and improvement in social vocational and psychological adaptation are related but not parallel. Less than total rehabilitation may be a more feasible therapeutic goal in many cases, rather than focusing on total abstinence or total psychosocial recovery. The low success rates for treatment may not reflect inadequate treatment methods but rather the failure to accept partial degrees of improvement as worthwhile.

Use with discretion

V. Abstinence as a necessary condition for successful treatment is an overstatement not verified by either clinical or research evidence. Abstinence may be necessary as a condition of treatment or at some time during treatment, but I would argue that abstinence as a condition of treatment is a prescription that should be used by the therapist with discretion, as with any other therapeutic manoeuvre, and that the goals of treatment—whether abstinence, psychosocial rehabilitation or characterological changes—are goals that must be determined with each patient. Different treatment approaches and different objectives are required for different alcoholics.

VI. Abstinence as a criterion of successful treatment is misleading: it says nothing about overall improvement in other areas of life functioning, and abstinence may as well be followed by psychosocial deterioration.

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The LSD Experience

By E. F. W. Baker, M.D., D. Psych., F.R.C.P.(C.)

It is possible to consider the person as divided into four components: sensory input, motor output, level of alertness, and integration of these with each other and with past integrations. LSD and other drugs of its type affect all four of these components in a characteristic combination: they enhance input, challenge integration, markedly alert the organism, and condense motor output. LSD makes you a much more receptive and thoughtful animal during its period of action.

Sensory input

Among the simple sensations, a glass of cool water may feel icy cold—the coldest thing you ever felt or could possibly tolerate; the colours of a match flame may be vivid—bright purples and oranges; vision may become acute: you might be more interested in the dots that make up the print of a photograph than in the over-all photograph. The senses may be listed as smell, sight, taste, hearing, balance, touch, pressure, pain, temperature, sense of displacement in space, sense of position, sense of joint movement, and visceral sensations such as stomach fullness, nausea and the rest. All these various sensations are enhanced—a tremendous inrushing flood. Combinations of raw sensations abound, evoking images of shape, size, weight and texture. These various sensations come through stronger and last longer. The movement of your hand before your eyes will give you an effect like a multiple flash picture, or perhaps like ectoplasm—it takes sensory input that much longer to fade away.

Motor output, on the other hand, is simplified and condensed. The mountain of one's intense experience may labour and pro-

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duce a mouse of action, like Prometheus flicking the ash off his cigarette; but one punch into a pillow by a person who habitually hides aggression can constitute a major breakthrough towards proper healthy self-assertion, and even the simple acceptance of a glass of water can have major meanings.

The simplified motor output induced by LSD may, of course, be dangerous. For instance, fully integrated acts of violence, attack, assault—anti-social “acting-out” of many kinds—are possible. Early on in our experiments we did not restrain the subjects during their LSD experience, but we soon learned it was better to do so. The first case that showed a potential towards violence luckily was a lightweight: a boy of fourteen who walked out of the room past the nurse and started to beat up the elevator man with a chain. Apparently the elevator man looked to him like his father, and he did not like his father.

Under LSD you are prone to vomit, cry, laugh, argue, feel affection, and so on, more than usual. The simplest excessive motor expression is the grand mal epileptic seizure; LSD is, in fact, somewhat epileptogenic. In our case material, four out of 150 had seizures during LSD treatment, one of which was more or less continuous. This is more than the general population incidence of epilepsy, which is one in 200. On the other hand, some of these patients were predisposed to fits, through addiction to alcohol or barbiturates.

Alertness

As regards level of alertness, LSD is a very alerting, tensing, excitement-producing drug. The idea of delirium has always included the idea of clouding of consciousness along with a labile emotional state, misinterpretation of background noises and possible hallucinations and delusions. The typical example is delirium tremens; but in the D.T.'s, the patient is disoriented and later remembers only partially what has gone on; LSD produces delirium, so to speak, without clouding of consciousness. The patient is oriented at the time and can later remember the experience in full clarity.

In regard to the combining of the sensory, motor and alerting segments with the rest of the person, it is possible to picture that the personality—normal or neurotic—is the result of previously built-up experience, reflexes, thoughts and feelings. It appears that LSD opens up this integrative central classifying agency. Here are a few examples:

The word evokes the object

Sensory-to-sensory integrations: A word heard may evoke the visual image of the object—an example of sign-object reversal. For instance, the word “peanut” evoked for one subject the visual image of a huge peanut; the shape of the peanut was made up from the chance folds of the counterpane, and the basic colour—beige—was filled in by sheer hallucination.

Motor-to-sensory integrations (this may be called motor evocation of sensory recall): One subject, who had musical training as a young child, could hear the whole range of the piano keyboard in full bright clarity by tapping the metal panel at the head of the bed.

Integration—sensory re-working: It is a commonplace for us to find that food tastes differently according to whether the doctor or the nurse feeds the patient. It is usually possible to relate this to the patient's attitudes towards his father and mother. For instance, a spoonful of soup might taste all peppery and thin when given by the doctor; it might taste rich and creamy when given by the nurse. From this we can conjecture the patient's basic triangle relationships.

In our attempted psychotherapeutic and psychiatric training use of LSD we have made much use of the distortions the patient makes of the doctor and the nurse (who typically sit at either side of the bed). When the distortions are defined, we bend every effort to make them meaningful and insightful, and we attempt to discover a plan of action for the patient. Obviously, a plan of action, however good, needs to be worked into real life if there is to be any real improvement in the patient.

We gave 150 non-psychotic patients one to ten LSD experi-

ences in a controlled setting and with therapeutic intention; we reported these in 1964.¹ Further observation bears out our early report: 100, or two-thirds, appeared to have been helped as a result of insight gained. Those who appeared to have been especially helped were phobic neurotics, hysterics and people who were between bouts of manic-depressive psychosis.

Subjects were selected after thorough history-taking, physical examination and diagnosis of functional non-psychotic psychiatric illness—often after trials of other therapy had failed or had reached an impasse. Subjects who might not be able to stand excitement—for example, those with arteriosclerotic cardiovascular disease—were not accepted. Anyone currently psychotic was not accepted. Risks were weighed in the case of subjects known to be epileptic, previously psychotic or thought to be pre-psychotic. We treated nobody who was pregnant and no children; the age range of our subjects was fourteen to sixty-five.

Bad results were seizures in four out of 150 subjects, three-day continuing psychosis—terminated by electroconvulsive therapy—in four out of 150, and one suicide two weeks after the LSD experience. There was one other death, which may or may not be related: an epileptic molester of young girls, middle-aged, was found dead at home six weeks after his LSD experience. There was no autopsy.

No difference between groups

We also took a series of thirty chronic alcoholics from the Alcoholism and Drug Addiction Research Foundation of Ontario and gave ten of them LSD, ten a near-placebo and ten no drug.² All got the regular treatment program of the Foundation in addition. The results showed no difference as to sobriety, job stability, and the like. On looking back from the results to the experiment, it may be that another series will allow prediction of

¹ E. F. W. Baker, The Use of Lysergic Acid Diethylamide in Psychotherapy, *Canadian Medical Association Journal*, 91 (1964), 1200-1202.

² R. G. Smart, T. Storm, E. F. W. Baker and L. Solursh, *Lysergic Acid Diethylamide (LSD) in the Treatment of Alcoholism*. (To be published in the Brookside Monograph series by the Addiction Research Foundation, Toronto.)

outcome. Those who later did well showed features under the LSD that distinguished them from those who later did poorly. The good-outcome alcoholics all wanted to live, all showed a good correlation between their actions and their words, and all felt univalently towards the nurse—either for or against. How they saw the doctor or felt about him did not seem to affect the outcome either way. The poor-outcome alcoholics all wanted to die, all would say one thing and do another, and all demonstrated ambivalence—love-hate combinations—towards the nurse.

To sum up: LSD temporarily widens sensory input, tends to temporarily break up mental integrations, makes you very alert, and condenses motor output. It is one of a class of compounds that may be called hallucinogens, which produce a hallucinatory state in clear consciousness—to be distinguished from drugs or toxins that produce delirium and clouding of consciousness.

White-Collar Pill Party

By Bruce Jackson, M.A.

Drugs, like chewing gum, TV, oversize cars, and crime, are part of the American way of life. No one receives an exemption.

This was made particularly clear to me recently by my four-year-old son, Michael, who came into the kitchen one evening and asked me to go out and buy a certain brand of vitamin pills for him. Since he is quite healthy and not observably hypochondriac, I asked why he wanted them. "So I can be as strong as Jimmy down the block."

"There isn't any Jimmy down the block," I said, whereupon he patiently explained that the clown on the 5 P.M. TV program he watches every day had *told* him the pills would make him stronger than Jimmy, and his tone gave me to understand that the existence of a corporeal Jimmy was irrelevant: the true-hearted clown, the child's friend, had advised the pills, and any four-year-old knows a clown wouldn't steer you wrong.

Of course you have a headache

For adults the process is modified slightly. An afternoon TV commercial urges women to purchase a new drug for their "everyday headache" (without warning them that anyone who has a headache every day should certainly be consulting a GP or a psychiatrist); a Former Personality with suggestive regularity tells you to keep your bloodstream pure by consuming buffered aspirin for the headache you are supposed to have, and another recommends regular doses of iron for your "tired blood." It won't be long before another screen has-been mounts the TV-commercial podium with a pill that doesn't do any-

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thing at all; it just keeps your corpuscles company on the days you ate liver and forgot to have a headache.

One result of all the drug propaganda and the appalling faith in the efficacy of drugs is that a lot of people take a lot more pills than they have any reason to. They think in terms of pills. And so do their physicians: you fix a fat man by giving him a diet pill, you fix a chronic insomniac by giving him a sleeping pill. But these conditions are frequently merely symptoms of far more complicated disorders. The convenient prescription blank solves the problem of finding out what the trouble really is—it makes the symptom seem to go away.

How many do you know?

Think for a moment: how many people do you know who cannot stop stuffing themselves without an amphetamine and who cannot go to sleep without a barbiturate (over *nine billion* of those produced last year) or make it through a work-day without a sequence of tranquillizers? And what about those six million alcoholics, who daily ingest quantities of what is, by sheer force of numbers, the most addicting drug in America?

The publicity goes to the junkies, lately to the college kids, but these account for only a small portion of the American drug problem. Far more worrisome are the millions of people who have become dependent on commercial drugs. The junkie *knows* he is hooked; the housewife on amphetamine and the businessman on meprobamate hardly ever realize what has gone wrong.

Sometimes the pill-takers meet other pill-takers, and an odd thing happens: instead of using the drug to cope with the world, they begin to use their time to take drugs. Taking drugs becomes *something to do*. When this stage is reached, the drug-taking pattern broadens: the user takes a wider variety of drugs with increasing frequency. For want of a better term, one might call it the white-collar drug scene.

I first learned about it during a party in Chicago last winter, and the best way to introduce you will be to tell you some-

thing about that evening, the people I met, what I think was happening.

There were about a dozen people in the room, and over the noise from the record player scraps of conversation came through:

"Now the Desbutal, if you take it with this stuff, has a peculiar effect, contra-indication, at least it did for me. You let me know if you . . ."

"I don't have one legitimate prescription, Harry, not *one!* Can you imagine that?" "I'll get you some tomorrow, dear."

". . . and this pharmacist on Fifth will sell you all the leapers [amphetamines] you can carry—just like that. Right off the street. I don't think he'd know a prescription if it bit him." "As long as he can read the labels, what the hell."

"You know, a funny thing happened to me. I got this green-and-yellow capsule, and I looked it up in the Book, and it wasn't anything I'd been using, and I thought, great! It's not something I've built a tolerance to. And I took it. A couple of them. And you know what happened? *Nothing!* That's what happened, not a goddamned thing."

The catalogue

The Book—the *Physicians' Desk Reference*, which lists the composition and effects of almost all commercial pharmaceuticals produced in this country—passes back and forth, and two or three people at a time look up the contents and possible values of a drug one of them has just discovered or heard about or taken. The Book is the pillhead's "Yellow Pages": you look up the effect you want ("Sympathomimetics" or "Cerebral Stimulants," for example), and it tells you the magic columns. The pillheads swap stories of kicks and sound like professional chemists discussing recent developments; others listen, then examine the *PDR* to see if the drug discussed really could do that.

Eddie, the host, a painter who has received some recog-

niton, had been awake three or four days, he was not exactly sure. He consumes between 150 and 200 milligrams of amphetamine a day, needs a large part of that to stay awake, even when he has slipped a night's sleep in somewhere. The dose would cause most people some difficulty; the familiar diet pill, a capsule of Dexamyl or Eskatrol, which makes the new user edgy and over-energetic and slightly insomniac the first few days, contains only ten or fifteen milligrams of amphetamine. But amphetamine is one of the few central nervous system stimulants to which one can develop a tolerance, and over the months and years Ed and his friends have built up massive tolerances and dependences. "Leapers aren't so hard to give up," he told me. "I mean, I sleep almost constantly when I'm off, but you get over that. But everything is so damned boring without the pills."

I asked him if he knew many amphetamine users who have given up the pills.

"For good?"

I nodded.

"I haven't known anybody that's given it up for good." He reached out and took a few pills from the candy dish in the middle of the coffee table, then washed them down with some Coke.

"Get some for me."

The last couple to arrive—a journalist and his wife—settled into positions. The wife was next to me on the oversize sofa, and she skimmed through the "Product Identification Section" of the *PDR*, dozens of pages of pretty colour photos of tablets and capsules. "Hey!" she said to no one in particular. Then, to her husband, "Look at the pretty hexagonal. George, get the Source to get some of them for me." George, across the table, near the fire, nodded.

I had been advised to watch him as he turned on. As the pills took effect something happened to the muscles of his face, and the whole assembly seemed to go rubbery. His features

settled lower and more loosely on the bones of his head. He began to talk with considerably more verve.

A distractingly pretty girl with dark brown eyes sat at the edge of our group and ignored both the joint making its rounds and the record player belching away just behind her. Between the thumb and middle finger of her left hand she held a pill that was blue on one side and yellow on the other; steadily, with the double-edged razor blade she held in her right hand, she sawed on the seam between the two halves of the pill. Every once in a while she rotated it a few degrees with her left index finger. Her skin was smooth, and the light from the fireplace played tricks with it, all of them charming. The right hand sawed on.

Looking it up

I got the Book from the coffee table and looked for the pill in the pages of colour pictures, but before I found it, Ed leaned over and said, "They're Desbutal Gradumets. Abbott Labs."

I turned to the "Professional Products Information" section and learned that Desbutal is a combination of Desoxyn (methamphetamine hydrochloride, also marketed as Methedrine) and Nembutal, that the pill the girl sawed contained fifteen milligrams of the Desoxyn, that the combination of drugs served "to both stimulate and calm the patient so that feelings of depression are overcome and a sense of well-being and increased energy is produced. Inner tension and anxiety are relieved so that a sense of serenity and ease of mind prevails." Gradumets, the Book explained, "are indicated in the management of obesity, the management of depressed states, certain behavioral syndromes, and a number of typical geriatric conditions," as well as "helpful in managing psychosomatic complaints and neuroses." Parkinson's disease, and a hangover.

The girl, obviously, was not interested in all of the pill's splendid therapeutic promises; were she, she would not have been so diligently sawing along that seam. She was after the methamphetamine, which like other amphetamines "depresses

appetite, elevates the mood, increases the urge to work, imparts a sense of increased efficiency, and counteracts sleepiness and the feeling of fatigue in most persons."

After what seemed a long while, the pill split into two round sections. A few scraps of the yellow Nembutal adhered to the Desoxyn side, and she carefully scraped them away. "Wilkinson's the best blade for this sort of thing," she said. I asked if she didn't cut herself on occasion, and she showed me a few nicks in her left thumb. "But a single-edge isn't thin enough to do it neatly."

"I might want to sleep."

She put the blue disk in one small container, the yellow in another, then from a third took a fresh Desbutal and began sawing. I asked why she kept the Nembutal since it was the Desoxyn she was after.

"Sometimes I might want to sleep, you know. I might *have* to sleep because something is coming up the next day. It's not easy for us to sleep, and sometimes we just don't for a couple or three days. But if we have to, we can just take a few of these." She smiled at me tolerantly, then returned to her blade and tablet.

When I saw Ed in New York several weeks later, I asked about her. "Some are like that," he said; "they like to carve on their pills. She'll sit and carve for thirty or forty minutes."

"Is that sort of ritual an important part of it all?"

"I think it is. She seems to have gotten hung up on it. I told her that she shouldn't take that Nembutal, that I have been cutting the Nembutal off my pills. It only takes about thirty seconds. And she can spend a good half hour at it if she has a mind to. I told her once about the effect of taking a spansule; you know, one of those big things with sustained release [like Dexamyl, a mixture of dextroamphetamine sulphate and amobarbital designed to be effective over a twelve-hour period]. What you do is open the capsule and put it in a little bowl and grind up the little pellets until it's powder, then stuff all the powder

back in the pill and take it, and it all goes off at once. I'll be damned if I haven't seen her grinding away like she was making matzo meal. That's a sign of a fairly confirmed head, when they reach that ritual stage."

Next to the candy dish filled with Dexedrine, Dexamyl, Eskatrol, Desbutal, and a few other products I hadn't yet learned to identify, near the five-pound box of Dexedrine tablets someone had brought, were two bottles. One was filled with Dexedrine Elixir, the other with Dexamyl Elixir. Someone took a long swallow from the latter, and I thought him to be an extremely heavy user, but when the man left the room, a lawyer told me he'd bet the man was new at it. "He has to be. A mouthful is like two pills, and if he was a real head, he'd have a far greater tolerance to the Dexedrine than the amobarbital, and the stuff would make him sleepy. Anyhow, I don't like to mess with barbiturates much anymore. Dorothy Kilgallen died from that." He took a drink from the Dexedrine bottle and said, "And this tastes better. Very tasty stuff, like cherry syrup. Make a nice cherry Coke with it. The Dexamyl Elixir is bitter."

A quiet high

Someone emptied the tobacco from a Salem and filled the tube with grass; he tamped it down with a Tinkertoy stick, crimped the tip, then lighted it and inhaled noisily. He immediately passed the joint to the person on his left. Since one must hold the smoke in one's lungs for several seconds to get the full effect, it is more economical for several people to turn on at once. The grass was very good and seemed to produce a quiet but substantial high. One doesn't notice it coming on, but there is a realization that for a while now the room has been a decidedly pleasant one, and some noises are particularly interesting for their own sake.

I leaned back and closed my eyes for a moment. It was almost 5 a.m., and in three hours I had to catch a plane at O'Hare. "You're not going to *sleep*, are you?" The tone implied

that this group considered few human frailties truly gauche, but going to sleep was surely one of them. I shook my head no and looked to see who had spoken. It was Ed's wife; she looked concerned. "Do you want a pill?" I shook my head no again.

No proselytizing

Then, just then, I realized that Ed—who knew I was not a pill-user—had not once in the evening offered me one of the many samples that had been passed around, nor had anyone else. Just the grass, but not the pills. His wife suggested a pill not so that I might get high, but merely so that I could stay awake without difficulty.

"I'm not tired," I said, "just relaxing." I assured her I wouldn't doze off. She was still concerned, however, and got me a cup of coffee from the kitchen and offered some Murine from her purse.

The front door opened, and there was a vicious blast of winter off Lake Michigan. Ed kicked the door closed behind him and dumped an armful of logs by the fireplace, then went back into the kitchen. A moment later he returned and passed around a small dish of capsules. And this time it was handed to me. They looked familiar. "One a Days," he said. I had learned enough from the Book to see the need for them: the amphetamine user often does not eat for long periods of time (some days his only nourishment is the sugar in the bottles of soda which he drinks to wash down the pills and counter their side-effect of dehydration of the mouth), and he not only tends to lose weight but also risks vitamin deficiencies. After a while, the heavy user learns to force-feed himself or go off pills every once in a while in order to eat without difficulty and to keep his tolerance level down.

Later, getting settled in the plane, I thought, What a wild party that was. I'd never been to anything quite like it, and I began making notes about what had gone on. Not long before we came into Logan, it suddenly struck me that there had

been nothing wild about the party at all, nothing. There had been women there, some of them unaccompanied and some with husbands or dates, but there had been none of the playing around and sexual hustling that several years of academic- and business-world parties had led me to consider a correlative of almost any evening gathering of more than ten men and women: no meaningful looks, no wisecracks, no "accidental" rubbing. No one had spoken loudly, no one had become giggly or silly, no one had lost control or seemed anywhere near it. Viewed with some perspective, the evening seemed nothing more than comfortable.

There are various ways to acquire the pills, but the most common is also the most legal: prescriptions. Even though there is now a federal law requiring physicians and pharmacists to maintain careful records regarding prescriptions for drugs like Dexamyl,* many physicians are careless about prescribing them, and few seem to realize that the kind of personality that needs them is often the kind of personality that can easily acquire an overwhelming dependence on them. Often a patient will be issued a refillable prescription; if the patient is a heavy user, all he needs to do is visit several physicians and get refillable prescriptions from each. If he is worried that a cross-check of druggists' lists might turn up his name, he can easily give some of his doctors false names.

Not underworld types

There are dealers, generically called the Source, who specialize in selling these drugs; some give them away. They do not seem to be underworld types but professional people in various capacities who, for one reason or another, have access to large quantities of them. If one is completely without connections, the drugs can be made at home. One young man I know made

*Similar records are required of physicians and pharmacists in Canada under Part III of the Food and Drug Act.

mescaline, amphetamine, methamphetamine, LSD, and DET and DMT (diethyl- and dimethyltryptamine, hallucinogens of shorter duration and greater punch than LSD) in his kitchen. In small lots, dextroamphetamine sulphate costs him about 50 cents a gram; a pound costs him about \$30 (the same amounts of Dexedrine at your friendly corner druggist's would cost, respectively, about \$10 and \$4,200).

In some areas, primarily those fairly distant from major centres of drug distribution, the new law has begun to have some significant effect. In one medium-sized city, for example, the price of black-market Dexamyl and Eskatrol spansules has risen from 15 cents to 50 cents a capsule, when one can connect for them at all.

In the major cities one can still connect, but it is becoming more difficult. The new law will inhibit, but there may be complications. It would be unfortunate if the price should be driven up so high that it would become profitable for criminal organizations to involve themselves with the traffic, as was the case with opiates in the 1940's and 1950's and alcohol in the 1920's.

LSD became cheaper

There was talk in Manhattan last winter, just before the new law took effect, that some LSD factories were closing down, and I know that some Sources stopped supplying. For a short time the price of LSD went up; then things stabilized, competition increased, a new packaging method developed popularity (instead of the familiar sugar cubes, one now takes one's dose on a tiny slip of paper; like a spitball, only you don't spit it out), and now the price for a dose of LSD is about 20 per cent *less* than it was a year ago.

Since most of the pillheads I'm talking about are middle-class and either professional or semi-professional, they will still be able to obtain their drugs. Their drugs of choice have a legitimate use, and it is unlikely that the government's attempt to prevent diversion will be more than partially successful.

If our narcotics agents have been unable to keep off the open market drugs that have no legitimate use at all—heroin and marihuana—it hardly seems likely that they will be able to control chemicals legitimately in the possession of millions of citizens. I asked one amphetamine-head in the Southwest how local supplies had been affected by the new law. “I heard about that law,” he said, “but I haven’t seen anybody getting panicked.” Another user tells me prices have risen slightly, but not enough yet to present difficulties.

A different group

There are marked differences between these drug users and the ones who make the newspapers. They’re well educated (largely college graduates), older (twenty-five to forty), and middle-class (with a range of occupations: writers, artists, lawyers, TV executives, journalists, political aides, housewives). They’re not like the high-school kids who are after a kick in any form (some of them rather illusory, like one psychosomatic gem reported to me by a New Jersey teen-ager: “What some of the kids do is take a cigarette and saturate it with perfume or hair-spray. When this is completely soaked in and dry, they cup the cigarettes and inhale every drag. Somehow this gives them a good high”), or college students experimenting with drugs as part of a romantic program of self-location. The kids take drugs “because it’s cool” and to get high, but when you talk to them you find that most ascribe the same general high to a wide range of drugs that have quite diverse effects; they’re promiscuous and insensitive. There is considerable evidence to suggest that almost none of the college drug users take anything illegal after graduation, for most of them lose their connections and their curiosity.

It is not likely that many of the thousands of solitary amphetamine abusers would join these groups. They take drugs to *avoid* deviance—so they can be fashionably slim, or bright and alert and functional, or so they can muster the *quoi que* with which to face the tedium of housework or some other dull job

—and the last thing they want is membership in a group defined solely by one clear form of rule-breaking behaviour. Several of the group members were first turned on by physicians, but a larger number were turned on by friends. Most were after a particular therapeutic effect, but after a while interest developed in the drug for its own sake and the effect became a cause, and after that the pattern of drug-taking overcame the pattern of taking a specific drug.

Speed-heads who specialize

Some of the socialized amphetamine-users specialize. One takes Dexedrine and Dexamyl almost exclusively; he takes other combinations only when he is trying to reduce his tolerance to Dexamyl. Though he is partly addicted to the barbiturates, they do not seem to trouble him very much, and on the few occasions when he has had to go off drugs (as when he was in California for a few months and found getting legal prescriptions too difficult and for some reason didn't connect with a local Source), he has had no physiological trouble giving them up. He did, of course, suffer from the overwhelming depression and enervation that characterize amphetamine withdrawal. Most heads will use other drugs along with amphetamine—especially marihuana—in order to appreciate the heightened alertness they've acquired; some alternate with hallucinogens.

To the heroin addict, the square is anyone who does not use heroin. For the dedicated pillhead there is a slightly narrower definition: the square is someone who has an alcohol dependence; those who use nothing at all aren't even classified. The boozers do bad things, they get drunk and lose control and hurt themselves and other people. They contaminate their tubes, and whenever they get really far out, they don't even remember it the next day. The pillhead's disdain is sometimes rather excessive. One girl, for example, was living with a fellow who like her, was taking over five hundred milligrams of amphetamine a day. They were getting on well. One night the two

were at a party, and instead of chewing pills, her man had a few beers; the girl was furious, betrayed, outraged. Another time, at a large party that sprawled through a sprawling apartment, a girl had been on scotch and grass and she went to sleep. There were three men in the room, none of them interested in her sexually, yet they jeered and wisecracked as she nodded off. It was 4 or 5 A.M. of a Sunday, not too unreasonable a time to be drowsy. When they saw she was really asleep—breaking the double taboo by having drunk too much scotch and been put to sleep by it—they muttered a goddamn and went into another room; she was too depressing to have around.

There is an important difference in the drug-use patterns of the pillhead and the opiate dependent: the latter is interested only in getting his drug and avoiding withdrawal; the former is also interested in perceiving his drugs' effects. I remember one occasion attended by someone who had obtained a fairly large mixed bag. In such a situation a junkie would have shot himself insensible; this fellow gave most of his away to his friends. With each gift he said something about a particular aspect of the drug that he found interesting. The heroin user is far less social. His stuff is too hard to get, too expensive, his withdrawal too agonizing. But the pillhead is an experimenter. Often he seems to be interested as much in observing himself experiencing reactions as he is in having the reactions.

'the pillheads' ritual

A large part of the attractiveness may be the ritual associated with this kind of group drug abuse: the *PDR* (a holy book), the Source (the medicine man whose preparations promise a polychromatic world of sensory and mystical experiences), the sharing of proscribed materials in a closed community, the sawing and grinding, the being privy to the Pythian secrets of colours and milligrams and trade names and contra-indications and optimum dosages. And, of course, using drugs is something of a fad.

But there are costs. Kicks are rarely free in this world, and

drugs are no exception. One risks dysfunction; one can go out of one's head; one may get into trouble with the police. Though the users are from a socio-economic class that can most likely beat a first offence at almost anything, there is the problem that legal involvement of any kind, whether successfully prosecuted or not, can cause considerable embarrassment; an arrest for taking drugs may be negligible to a slum dweller in New York, but it is quite something else for a lawyer or reporter. And there is always the most tempting danger of all: getting habituated to drugs to such a degree that the drugs are no longer something extra in life but are instead a major goal.

"That first voom-voom pill"

One user wrote me: "Lately I find myself wishing not that I might kick the lunatic habit—but simply that our drug firms would soon develop something NEW which might refresh the memory of the flash and glow of that first voom-voom pill." I had asked him why take them at all, and he wrote: "I don't know. Really. Why smoke, drink, drive recklessly, sunbathe, fornicate, shoot tigers, climb mountains, gamble, lie, steal, cheat, kill, make war—and blame it all largely on our parents. Possibly to make oneself more acceptable to oneself."

Many of the pillheads are taking drugs not *only* to escape but also to have an experience that is entirely one's own. There is no one else to be propitiated, there are no explanations or excuses needed for what happens inside one's own head when one is turned on; words won't do, and that is as much a benefit as a disadvantage, because if you cannot describe, then neither can you discuss or question or submit to evaluation. The benefit and the risk are entirely one's own. Indiana University sociologist John Gagnon pointed out at a drug symposium held at Antioch College last year: "I'd like to argue that possibly in our attempt to protect people, we have under-represented the real payoff for drug-taking as an experience, as a risk people want to run."

You select your own risks—that's what living is all about.

For some of these drug users, the risks currently being marketed do not have very much sales appeal: going south for the summer with SNCC is out because they feel that they are too old and that ofays aren't much wanted anyhow; going to Vietnam for Lyndon is absurd. So they go inside. A scarier place, but no one else can muddle around with it.

An exercise in coping

There is nothing *wrong* with using chemicals to help cope with life. That is one of the things science is supposed to do, help us cope, and the business of living can be rough at times. And we have the requisite faith: I am sure that far more Americans believe in the efficacy of a pill than believe in God. The problem arises when one's concern shifts so that life becomes an exercise in coping with the chemicals.

I think there has been an unfortunate imbalance in the negative publicity. For years the press has printed marvellous tales about all the robberies and rapes performed by evil beings whose brain tissues have been jellied by heroin. But it has rarely printed stories that point out that opiates make even the randiest impotent, or that alcohol, which has five hundred times as many addicts, is an important factor in sex offences and murders.

A far more serious problem

Lately, attention has been focused on drug abuse and experimentation among college students. Yet all the college students and all the junkies account for only a small portion of American drug abuse. The adults, the respectable grown-ups, the nice people who cannot or will not make it without depending on a variety of drugs, present a far more serious problem. For them the drug experience threatens to disrupt or even destroy life patterns and human relationships that required many years to establish.

And the problem is not a minor one. Worse, it seems to be accelerating. As Ed advised one night, "You better research

the hell out of it because I'm convinced that the next ruling generation is going to be all pillheads. I'm convinced of it. If they haven't dysfunctionalized completely to the point where they can't stand for office. It's getting to be unbelievable. I've never seen such a transformation in just four or five years . . ."

Addictions

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ADDICTIONS is published four times a year by the Addiction Research Foundation, an agency of the Province of Ontario.

The contents of each issue are selected on the basis of their potential interest to persons engaged in research, treatment or education in the field of alcoholism and drug addiction.

Articles published in ADDICTIONS do not necessarily reflect the views of the Foundation.

If you would like to receive ADDICTIONS regularly, or if you would like to know more about some aspects of the Foundation's work, you are invited to write to:

Addiction Research Foundation,
Education Division,
344 Bloor Street West,
Toronto 4,
Ontario.

Because this Foundation is a provincial agency, any resident of Ontario is entitled and welcome to receive ADDICTIONS, whether he is working in this field or not; but if you have a professional interest in the field, please indicate it when you write. We regret that we cannot send ADDICTIONS to non-professionals outside Ontario.

The Foundation has offices at:

Toronto (365-4521)—344 Bloor Street West
—221. Elizabeth Street

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Editor: Alasdair McCrimmon



Authorized as second class mail by
the Post Office Department, Ottawa,
and for payment of postage in cash.

A.I.+ Addictions

Volume 14, Number 4

Winter, 1967

The Revolving Door:

A Functional Interpretation

By P. J. Giffen, M.A.

Anatole France has said: "The law in its majestic equality forbids the rich as well as the poor to sleep under bridges, to beg in the street, to steal bread." To this we may add: it also forbids the rich as well as the poor to be drunk in a public place. The distinction between a private and a public place is an old and honourable one in our legal tradition. The institution of privacy, sanctified in law, has given us considerable freedom from coercion when under our own roofs. But since, in keeping with this tradition, the law has defined certain acts—such as getting too drunk to walk properly—as legitimate if done in private but illegal if done in public, it has loaded the dice against the lower classes. Social class and access to private places are closely related—particularly access to enough private places to cover most of one's social life.¹ And since the law has made imprison-

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Arthur L. Stinchcombe, "Institutions of Privacy in the Determination of Police Administrative Practice," *American Journal of Sociology*, LXIX, 150-160 (September, 1963).

ment a penalty for the offence, it has in some measure helped to increase the offender's initial vulnerability by making it more difficult for him to keep a job, a residence, a family relationship, and other ties to private places. It is the end result of such a process that we are concerned with in this article: the chronic drunkenness offender, or what has become known as the "revolving door" problem.

Examine social systems

The term "revolving door" is descriptive of the cycle of public intoxication, arrest, trial, incarceration, and release that dominates the life of the Skid Row alcoholic. Since he is the very model of the recidivist and, once involved in this pattern, rarely escapes, it is obvious that an overriding consequence of the revolving-door phenomenon—the police, the courts, the jail, and Skid Row drinking society—is the perpetuation of the proscribed behaviour. To understand how this is brought about, it is necessary to examine some of the functions performed for both the community and the offenders by these several systems.

The statements that follow are based on a study of chronic drunkenness offenders in Ontario that has extended over several years and was initiated and financed by the Addiction Research Foundation of Ontario. The chief sources of data have been:

- an interdisciplinary study of some 230 chronic offenders in the Toronto Jail, comprising extended interviews, a medical examination and laboratory tests, psychological tests, psychiatric examination, and documentary data from various sources;

- a shorter interview study of a sample of 50 first offenders

- basic information on the 18,000 male public intoxication cases that appeared in Toronto's G Court over a period of a year, and some comparable information from the court of a smaller city;

- mailed questionnaires to chief constables and magistrates throughout Ontario; and

—participant observation of Skid Row drinking groups and police arrest practices.

. The Police

The police have considerable discretion in the use they make of public intoxication laws, as the offence of drunkenness in a public place itself is very common and the initiative in making an arrest almost always lies with the police officer. The choice of arrestees is a sampling procedure, but not a random one. The Ontario chief constables were frank in admitting that the power to arrest for this offence is used highly selectively, and our own observations substantiated this. The recurrent theme in the chief constables' replies was that the drunk must be creating a disturbance or be likely to do so, or he must be in some danger of coming to harm. One police chief stated: "A person may be under the influence, but if he or she appears to be able to look after himself and is not bothering others while making his way home he is usually not molested." Another said: "Our officers are instructed not to arrest persons who are able to navigate under their own power without interfering with other persons. We drive a large number of persons to their homes if they are co-operative and give their addresses."

Arrest more likely

The homeless, unattached drinker, as well as being more likely to appear in public when he is drunk, is also more likely to come to harm, since he frequently has no sheltered place to go to and nobody to look after him. However, the police in large urban centres usually do not take time to determine whether the man has a home. They are likely to make quick judgements based on such externals as dress, companionship, and location—and, perhaps, recognition of the inebriate as a regular customer. This appears in the replies of the police chiefs in such phrases as: "Usually persons who are homeless and bothering people . . . or drawing attention to themselves," and "The habitual offender

is charged on every occasion." Data on the occupations, addresses, and marital status of offenders indicate that the public intoxication charge is, in fact, used most commonly as a means of dealing with homeless, unattached drinkers. Others are also caught up in the net but they, too, are mostly from the lower classes.

Traffic courts different

An important constraint on the over-zealous indiscriminate use of the public intoxication arrest is the opposition that would result from the interruption of role-performances if large numbers of productive citizens were punished for a trivial offence of no political significance.² It is instructive that in minor traffic offences, where the police sampling method inevitably nets many offenders with jobs and other responsibilities, the procedures for handling the cases differ markedly from public-intoxication cases. Traffic offenders are generally summoned to appear, allowed to avoid trial by advance payment of the fine, and even, in some communities, provided with a night court. In contrast, drunkenness offenders are usually arrested and held for trial rather than summoned, and they are forced to appear in court during working hours—a system obviously attuned to a clientele that is predominantly jobless and without duties to families or other organizations.

One interpretation of this role of the police is that of residual social control, a responsibility that is theirs because no others are concerned. Better-off drinkers, in addition to having homes in which to drink, and taxis and cars in which to get there, are caught up in a network of relationships with others who will likely make efforts to protect them from harm and prevent their disruptive behaviour from becoming public. This role of law-enforcement agencies as a form of social control increases as one goes down the social scale, and takes in other forms of deviance. Hollingshead and Redlich in their study of mental

²Abraham Flexner argues that the customers of prostitutes for this reason are rarely charged with an offence. *Prostitution in Europe* (New York, 1920), 108

illness and class structure, for example, found that 52.2 per cent of the psychotics in the lowest class were brought or sent for treatment by the police or the courts, but that none of those in the two highest classes entered treatment by this route.³

Insofar as public intoxication laws are used for the control of homeless, unattached men, they converge in function with vagrancy laws. The "idle rogues and vagabonds" at which such laws have for centuries been aimed have been seen as a threat to the community precisely because they are detached from normal social controls—aliens who are dangerous because they have nothing to lose. The drunk arrest may serve the police as the easiest means of keeping down the number of such men in circulation—easiest because conviction is almost automatic and the police are rarely called upon to testify.

Rarely commit assaults

It is significant that chief constables who were polled were overwhelmingly opposed to removing the offence from the statute books and that their stated reasons frequently included the idea that an increase in other crime would result. One of the more strongly stated responses was: "If these persons were allowed to roam the streets in an intoxicated condition without fear of arrest or punishment, I can see any number of crimes, rape, robbery, thefts, assaults, being committed as a result." It would seem, then, that the high arrest rate of homeless drunks is partly due to this police concern with preventative control. There is a slim empirical basis for this, in that some chronic offenders do commit occasional petty thefts when at large. But their criminal records also show that they very rarely commit assaults or other offences against the person once they become fully involved in the revolving door.

However, for the police the responsibility for dealing with drunks is a mixed blessing. Their job is complicated by the fact that the offenders may be sick or semi-comatose and—

A. B. Hollingshead and F. C. Redlich, *Social Class and Mental Illness* (New York, 1958), 187.

perhaps more important—they may have injuries, some of them hidden, or be suffering from an acute illness. Since they are by definition criminal offenders and are by custom arrested rather than summoned, the presumption is that they should be put in the lock-up unless there are reasons apparent to a layman for taking them to a hospital. Every so often an alleged drunk dies while in custody, or commits suicide, and the police are the subject of unfavourable publicity. This is one of the junctures at which the priority of the “criminal” over the “illness” definition of intoxication is clearly dysfunctional for the police.

Alienation is reinforced

The consequences of this arrest pattern for the chronic offenders are several. In terms of their physical welfare, and perhaps survival, the net result of having their drinking bouts terminated by arrest is beneficial.⁴ However, recognition of this is not prominent in the reactions of the chronic offenders themselves. They express strong animus against the police—stronger than their feelings against the courts, and in contrast to their generally accepting attitude towards the prison staff. They do not think that public intoxication should be an offence at all, and they regard the police as the people who in fact try and convict them, and that unfairly. More specifically, they complain that the police are much too zealous in arresting drunks who are harming nobody; that in doing so they discriminate on a class basis, particularly against men known to them as chronic offenders; that they are arbitrary and inconsistent, sometimes arresting men who are not drunk and at other times overlooking extreme intoxication; and that they tend to insult known drunks and physically abuse them. The validity of these accusations is not relevant here. What is important is that such beliefs, with a strong emotional component, reinforce the alienation of the

⁴The medical study indicated that the health of the chronic offenders was surprisingly good. The main explanation appeared to be the role of the police in terminating sprees and the effect of incarceration in providing enforced recuperation and spacing sprees.

chronic offenders. They become part of the common culture of Skid Row and contribute to its solidarity as a persecuted out-group.

I. The Courts

Drunk trials are probably the most simple, rapid, and routinized of criminal proceedings, usually taking less than a minute from beginning to end. The cast of actors is cut to a minimum: lawyers rarely appear for the accused (they appeared in less than one case in a thousand in G Court); the prosecution is usually handled by a police officer; witnesses are almost never called; there are no newspaper reporters; and the few spectators are likely to be idle onlookers rather than interested parties. Since the overwhelming majority of the accused plead guilty, the court has only to pronounce sentence; and this is usually done according to a standard scale of punishment established by usage. Except for the occasional brief interchange, usually initiated by the accused who wants to put forward a plea for clemency, no argument is heard.

Perform two functions

Formally, the courts perform the same functions in drunk trials that they do in other criminal cases: what might be called the "sorting-out" function and the "legitimation" function. The sorting-out function is the outcome of the various decisions that result in a specific disposition of the case: decisions as to whether a trial should be held at all, decisions as to guilt or innocence, and decisions regarding the penalty. The accused are put into categories that define what, if anything, may be done with them subsequently. When the trial has in theory been conducted according to the rules, and the disposition is based on the law, what is subsequently done to the accused is legitimated. The authority of others over the offender while he is still in custody or under supervision is now legal and therefore morally acceptable, and may be backed by the use of force.

But the sorting-out function as it is performed in the drunk court is rudimentary and subject to conflicting expectations. The proving of guilt, as we have seen, is rarely necessary. Time-consuming weighing of alternative sentences tends to be discouraged by the triviality of the offence, by the limited choices open to the magistrate, and by the apparent lesson from experience that the recidivists are not going to be changed or deterred in any event.

Few real options

The number of ways that the magistrate can dispose of the case is limited not only by the law but also by the lack of facilities at the disposal of the court—particularly rehabilitative facilities that could be an alternative to imprisonment. Probation officers scarce in relation to the demand, are not often available for the supervision of drunkenness offenders. Alcoholism clinics or social welfare agencies dealing with this sort of man, if they exist rarely have liaison with the courts.⁵ In only a few jurisdictions is the magistrate given the option of sentencing offenders to a place of treatment. Some of the remaining sentencing choices open by law to the magistrates may be fictitious or inapplicable especially where chronic offenders are concerned. A fine may in theory be an alternative to a jail sentence, but it is not an alternative in fact unless the offender can pay. We found that some 40 per cent of the first offenders in G Court were unable to pay their fines, and that the proportion increased to 96 per cent among men up for their sixth or subsequent offence within the year. If the law allows the magistrate to give the accused time to pay his fine, he is under an obligation to consent to this only where the accused is a good credit risk. Consequently, the privilege is rarely granted to chronic offenders, and usually only to those first offenders who have a job and an address. In effect then, a fine is a jail sentence for most chronic offenders. The

⁵Although the Salvation Army is an exception, its emphasis on spiritual regeneration through religion is in contrast to the methods of professionally-managed agencies and appears to limit the type of person whom it can influence.

magistrate has little choice, and therefore has little reason to spend time exploring alternatives in court.

In sending the chronic offender to jail, the magistrate is exposed to a value conflict whose nature has been expressed graphically by an American municipal court judge of long experience:

"In this environment, we have been driven to extreme frustrations, in part because we have been handed the two accepted tools of criminal penalization—the fine and the jail sentence—to deal with what has appeared to us to be primarily a social and medical problem. We have found ourselves dissatisfied with these tools both on philosophical and practical grounds. On the one hand, we are cast in the role of the bully trampling down and further degrading those within our society who are already the weakest and most inadequate among us, ourselves frustrated by the realization that neither do we protect society by the prevention of law violations in this regard which, of course, is the basic function of all law enforcement."⁶

Courts in a bind

The generality of this conflict is to be seen in the following written conclusion from a 1959 conference of municipal court judges:

"The alcoholic is a compulsive offender who should be helped by the court rather than punished. . . . The municipal judge has the right, if not the duty, to inform his community that he is willing to continue to handle this health problem, but that he has not been given the tools to do the job. Until such tools are provided, a judge should not be required to incarcerate persons guilty of no offence other than their affliction with the illness of alcoholism."⁷

As these statements indicate, the current conflict in our society

Judge William Burnett, *Proceedings: Conference on the Alcoholic and the Court*, (Portland; Oregon State System of Higher Education, 1963), 5.

Proceedings: Processing the Alcoholic Defendant: Rocky Mountain Regional Conference of Municipal Judges (Washington: U.S. Government Printing Office, 1961), 90.

between the "illness" and "criminal" definitions of deviance may become a pressing one for the magistrate who is forced to be our agent in implementing one or the other. The illness definition, of course, implies that the proscribed behaviour is non-voluntary and that the appropriate response is treatment or some form of social repair rather than punishment. The traditional criminal definition assumes that the actor freely chooses to misbehave and that punishment according to a graded scale of seriousness and culpability is a justified response. The conflict is likely to appear rather sharply in dealing with offenders whose behaviour is attributable to an addiction, since the illness definition has come to be widely accepted in this sphere.

Claims for punishment weak

Most magistrates are likely to subscribe in some degree to the illness definition, while being required by law in most jurisdictions to treat the drunken behaviour of the homeless alcoholic as a punishable offence. Even if the magistrate subscribes to the criminal definition, he is probably forced to recognize that the traditional claims for the appropriateness of punishment are weak where chronic drunkenness offenders are concerned. First public drunkenness does not stand high in the scale of proscribed acts, and secular change undoubtedly has been in the direction of greater tolerance of inebriety. Second, he cannot believe that by sending the offender to jail he is protecting society by removing a dangerous felon from circulation. Third, he cannot long maintain a belief that punishment is a deterrent, although he may think that some first offenders learn a lesson. Moreover the appropriateness of punishment is challenged by the many manifest claims to sympathy of the chronic offenders. They appear to be unfortunates who have already been punished by circumstances: lonely, homeless, without a future, perhaps old and ill.

In Ontario the magistrate is allowed one way out of the dilemma. The Liquor Control Act enables him to sentence offender

to treatment within the reformatory system.⁸ But here the paradoxes of combining clinical decisions with the judicial role become manifest. When it came into force in 1961 the provision gave the magistrate the right to sentence *third* offenders to compulsory treatment, thus designating the traditional standard of punishability—the number of offences—as a criterion for treatment. Since the Act was amended in 1962 to allow courts to send for treatment any public intoxication offender “where it appears he may benefit therefrom,” magistrates have, on the whole, continued to regard recidivism as a condition of eligibility. Our study of first offenders has shown, as might be expected, that being in court for the first time does not preclude the presence of alcoholism or other conditions for which a clinician might recommend treatment.

The magistrate is given no guidance beyond the vague wording of the law, and provided with no professional help in making the decision about treatment. We have found that, as a consequence, magistrates tend to develop their own individual rules of thumb that can be quickly applied, and that these differ considerably among magistrates. For example, some feel that it is useless to send the older Skid Row alcoholics for treatment, and others feel that the treatment is appropriate only for men of this type. The research also showed that the courts throughout the province differ greatly in the proportion of offenders that they sent for treatment. For the treatment facility, this has meant an unpredictable flow of patients not of their own choosing. We have also found that magistrates, seeing their failures return, have tended to become pessimistic about the possibilities of treatment.

Strain on the courts

Despite their limitations as a sorting-out mechanism, the courts still formally perform the function of legitimation. But here, too, some qualifications are necessary. The legitimation

Revised Statutes of Ontario, 1960, chapter 217, with amendments.

provided by lower courts is provisional: the decisions can be challenged and upset in higher courts. On the two occasions in the last five years when proceedings in G Court have been challenged, the appellants have been successful. The grounds need not concern us here, but in both instances they involved practices or conditions common to most other trials in the court. We also found that in a period when the law prescribed minimum penalties, a large proportion of the sentences given chronic offenders were well below the statutory minimum. These distortions of the legal process can be interpreted as adaptations to the strains put on the courts by the requirement that they should deal with men of this type as criminal offenders. Undoubtedly, there are parallels in other jurisdictions.

The effect of the court experience on the offenders themselves is to add to their alienation. Their reactions to these trials are epitomized in the term "kangaroo court," which occurs so frequently in their conversation that it must be regarded as part of their common culture. In more detail, they complain: that "you can't beat a drunk charge" (a conviction is inevitable); that they are herded through (like a "bunch of sheep," as one man put it) that they are given no chance to tell their stories; that the magistrate and the policeman who conducts the prosecution are in cahoots, and so on. They complain much more frequently about the demeaning way in which they are treated than about the sentences they are given—which is not surprising in men accustomed to jail but highly conscious of their lack of status.

III. The Jail

In discussing the functions of the jail, we should make it clear that the "Don Jail" in Toronto, on which these observations are based, may not be typical. Many other jails may not possess in the same degree the conditions for the development of a stable and fairly complex occupational system manned almost entirely by drunkenness offenders. Since it is a large jail, and the more serious offenders awaiting trial or transfer to another institution

are not required to work, the many routine housekeeping and maintenance jobs are done by the inebriates who constitute 30 to 40 per cent of the jail population. A condition for stability is unwittingly filled by the police and the courts who send the "regulars" (the term itself is significant and derives from the jail) to jail frequently and for fairly extended periods. The justification for using this case is that it brings out in exaggerated form characteristics of the adjustment of chronic drunkenness offenders to all prisons and also that it makes particularly evident certain potentials of these men in such a setting.

The effects conventionally cited as functions of imprisonment can be dismissed out of hand where the "regulars" are concerned. "Incapacitation" is of consequence only in regard to offenders who are dangerous when at large. "Rehabilitation" is a job the jails do not pretend to do, and the recidivism characteristic of our group indicates that it is not accomplished unintentionally. However, the jail does provide an excellent setting for physical recuperation, as the results of our medical examinations showed.⁹

the "deterrence" function

"Deterrence" deserves more attention. Leaving aside the inappropriateness of this expectation where an addiction is involved, the jail experience is clearly not a painful one for the "regular." There is no need to linger on what are usually thought of as the deprivations of imprisonment; the chronic drunkenness offender is already stigmatized, and already alienated from his family and respectable friends; since he rarely if ever has sexual relations with women outside, their absence is not experienced as deprivation (certainly not for thirty days); he has no job to lose; and the food, sleeping accommodation, and other creature comforts are probably better and certainly more predictable than he finds outside.

Of more interest are the ways in which the experience is

⁹Most of the men were found to gain weight in jail. Since they were in jail frequently, this tended to prevent the *sequelae* of malnutrition associated with prolonged heavy drinking.

rewarding, and the fact that it complements and thus helps to maintain his pattern of life outside.

The system inside

To understand this we must examine, very sketchily, the jail system. Within the walls there is a differentiated occupational structure made up of at least 17 jobs or work crews, some of them employing up to 25 inmates. The guard (or it may be a civilian employee) in charge of each crew or job functions as an employer. When he recruits a new employee the main requirement is that the man should be a "regular"—somebody who can be depended upon to return frequently and for a respectable time—and also, of course, that the man should not already be employed by another crew chief who wants to keep him. The men who make the grade acquire a recognized right to the job, and can legitimately expect to be re-hired each time they are admitted. Formally, all prisoners are equal; but the jobs are informally graded in a rough hierarchy of prestige, related to the status of the people who are served, the freedom of movement the job allows, how close it is to the centres of communication in the jail, and the material rewards it carries. While there is no official payment, the jobs bring with them differences in the opportunities to get tobacco, extra food, changes in clothing, more frequent showers, and in some cases better quarters. Moving to a better job is possible for those who perform well, demotion is possible for those who abuse the opportunities of their jobs, and it is even possible, with time, to retire to the section of the jail reserved for the unemployables who have become too old to work.

The administration of the prison is judged largely on how well it looks after custody, internal order, and self-maintenance.¹⁰ The "regulars" are an asset in all these respects: they do not try to escape, they are orderly and tractable, and they fill most of the work roles of the internal economy. Not surpris-

¹⁰Gresham M. Sykes, *The Society of Captives* (Princeton, 1958), 18-30.

ngly, the relationships that evolve are in some ways closer to those of an ordinary work situation than a prison. A sympathetic relationship tends to develop between many of the "regulars" and the staff, particularly within the work crews. Like foremen in industry, the crew chiefs are dependent on the co-operation of the men who work for them and must make numerous small concessions to this end. The men, from their side, have come to place a positive value on co-operation with the staff: they are allies in getting a job done, as well as in circumventing some of the more burdensome rules. It is revealing that the men who are uncooperative on the inside are usually those who have only a marginal relationship with Skid Row drinking groups on the outside, and also that men who have previously had serious criminal careers are more likely to be uncooperative.

Alcohol not missed

The relatively responsible behaviour of the "regular" in his job tends to extend to other aspects of his life in jail. He is, for example, likely to read newspapers and news magazines and even to engage in discussions of public affairs—things he rarely does outside. The pattern of "sharing," which on the outside is likely to be confined almost entirely to alcohol, includes the other scarce material objects that are valued in jail and becomes a form of altruism in the common pattern of sharing smokes, extra food, and reading material with the old unemployables who cannot reciprocate. He of course abstains from drinking—external controls have made internal controls unnecessary—but he also states with conviction that he does not miss alcohol. Apparently the relatively rewarding character of jail life has something to do with this absence of craving.

The jail life that we have described must be seen as complementary to the life the "regulars" lead outside, and the two lives as mutually reinforcing. The men seem to become adjusted to an alternation of confinement and freedom—of stable, responsible living and chaotic licence. Consciously or unconsciously,

their motivation during life outside to eat regularly, govern their drinking, or get a job, may be attenuated by the predictability of arrest. Their disciplined lives in prison may in turn be made bearable by the anticipation of the period of uncontrolled drinking. At an unconscious level, their exemplary behaviour in a situation of unjustified punishment may have the significance of a licence to transgress when they are released. Or, if they are highly ambivalent—as they give evidence of being—life outside may serve to satisfy their alienative need-dispositions and life in prison, paradoxically, to satisfy their conformative need-dispositions.¹¹ Many interpretations are possible.

Finally, a word about the function of jail in the integration of Skid Row drinking society. It is in jail that men have the best chance to become acquainted with others like themselves and the newcomer has the best chance to become acculturated to Skid Row drinking norms. If you ask one of these men who he drinks with, he is quite likely to answer: "With guys I know from jail." The great majority of the men we studied served jail terms before they became full-fledged members of Skid Row society. If there were no jail, Skid Row drinking groups would undoubtedly exist; but they would probably be localized and fragmented, and recruitment to them would be much less efficient.

IV. Skid Row

Outside jail, membership in the society of Skid Row drinkers tends to perpetuate deviant behaviour. Their peers reward deviance with social acceptance and, without malice make social isolation the cost of going straight. It is a society of alcoholics oriented to collective drinking almost to the exclusion of activities that have no bearing on acquiring and consuming liquor and avoiding arrest. According to their norms of reciprocity, it is incumbent on the member to share his liquor

¹¹See Talcott Parsons, *The Social System* (Glencoe, Ill., 1951), 253-267.

to pool his money with others to purchase it, to share his knowledge of safe drinking places, to allow friends to drink in his room if he has found a tolerant landlord, and so on. But the sharing of other material benefits is largely irrelevant, and responsibility for looking after one's fellows is not expected. As one man put it: "You have to look out for yourself unless you are sick from booze. I mean they are only interested in you to drink with."

Since little is expected of participants, membership is easily granted: social background, education, age, and appearance are irrelevant. The few unacceptable individuals are likely to be those who are known to endanger the drinking group by their aggressive, noisy, or bizarre behaviour, and those who persistently fail to reciprocate in furnishing wine. This form of company is temptingly easy to acquire for the man who has nobody else and who has limited personal resources to spend in the friendship market. In drinking together, the illusion of warm camaraderie may be sustained for a while. One "regular" put it this way: "When you're drinking you're all close friends and buddies."

'Really no close friends'

It also seems that what is easily acquired is little valued. The men are likely when interviewed to denigrate their Skid Row companions, reflecting in some degree their own low self-esteem; to refer to their drinking friends as "bums," "drunks," or "Skid Row characters." One man expresses it: "If you're one of the boys you're O.K. in the District, but there are really no close friends in the District." They seem to be saying that these relationships are unsatisfying in that they differ from true primary relations found in the family or among close friends. What is lacking is the affect or emotion characteristic of primary relations and the diffuse obligation to help each other. The true primary relation is, of course, particularistic; individuals are not substituteable, whereas easy substitution is characteristic of Skid Row interaction. Drinking groups are continually breaking up; members disperse to meet up with others and form

new groups, sometimes going through several changes of companionship in a day.

Depends on society

The persistence of Skid Row drinking society in its present form obviously depends on the modes of redistributing the affluence of the host society. Money for the purchase of alcohol must be forthcoming through panhandling, and, to some extent, through pensions and welfare payments. The Skid Row drinkers also depend from time to time on the numerous charitable organizations that furnish food, clothing, and shelter. Although the alcoholics usually eat little when on a spree and sometimes find other places to sleep, the hostels and missions make it possible for them to meet these minimum creature requirements at critical junctures and thus enable them to get by without changing their behaviour. Some of the organizations go further in unwittingly encouraging dependence by serving meals at times that conflict with holding a job, requiring the men to leave the hostel if they are employed, and in other ways making help and a regular occupation incompatible.

Conclusions

The criminal role, as many writers following Durkheim have observed, is inherently alienating. Since punishment serves as an occasion for reaffirming the importance of common norms, as well as for displacing aggression, the criminal is in a sense a scapegoat. The secondary result is that he tends to be isolated from claims on others and, under the appropriate circumstances, driven into the company of persons who are similarly stigmatized. In a modern society with elements of a puritan tradition and a fondness for legislating, the official machinery for stigmatization may continue to apply to forms of proscribed behaviour that are no longer popularly regarded as criminal or dangerous. If the proscribed behaviour is also susceptible to definition as the symptom of an illness, the conditions are created for value-

conflict, compromises, and, eventually, fundamental changes that would make therapy or domiciliary care the dominant means of social control.

In the revolving door system as it now exists, the alienating effect of criminal stigmatization is added to the effects of alcohol addiction, and to other circumstances and personal characteristics that make for the isolation of the participants from kinship groups and from the occupational structure. Recruits to the revolving door find themselves in a system that supplies and rewards the addiction, while adding to the reasons for seeking relief from tension. The distribution of scarce professional services and related resources is such that the Skid Row inebriate is rarely involved in therapeutic relationships. If he is, the relationships are usually too superficial and short-lived to compete with the immediate gratifications that are easily available in the revolving door.

Brookside Monographs

The sixth in the Ontario Addiction Research Foundation's series of Brookside Monographs, *Lysergic Acid Diethylamide (LSD) in the Treatment of Alcoholism*, was published several weeks ago by the University of Toronto Press. The authors are Reginald Smart of the Foundation's research staff, Thomas Storm, then a Foundation researcher and now on the staff of the University of British Columbia, and Earle Baker and Lionel Solursh, both of Toronto Western Hospital and the University of Toronto.

The book reviews the history of the discovery and early use of LSD, discusses some of the possible dangers of its use, and examines its use in psychiatric treatment generally and in the treatment of alcoholism. The authors also report their own controlled trial of LSD with a group of alcoholic patients of the Foundation in Toronto.

The Toronto study involved a ten-patient LSD group, a ten-patient placebo (ephedrine sulphate) group and a ten-patient control group. All patients were also receiving the Foundation's regular treatment program. The LSD group did well, with eight out of ten rated "improved" or "much improved" at the six-month follow-up, but the placebo and control groups did just as well. The authors concluded that the improvements shown in the patients' drinking behaviour "could not be attributed to the use of LSD."

In their examination of eleven other studies of LSD in the treatment of alcoholism, the authors found similar results: groups that received LSD did no better than similar groups that did not receive LSD. The authors conclude that "reports that LSD was an effective adjunct to therapy for alcoholism may have resulted from lack of adequate controls in the evaluation of its utility."

Alcohol and Alcoholism In Traffic Accident Research

By Reginald G. Smart, M.A., Ph.D.

Few areas of human concern are attracting so much interest and publicity as are traffic accidents. Some experts have argued that little research has been done on the causes of accidents; but the author sides with others such as Jacobs (1961, p. 5), who believes that "contrary to popular belief, very much research effort has gone into the treatment of these problems over the last 50 years. Tremendous volumes of data have been collected and analyzed. A large force of individuals is continuously employed in accident investigation and reporting. Despite all of this it is difficult to point to more than a handful of research findings which have led to the development and application of useful countermeasures."

One of the best-explored areas, by way of survey, experiment, and naturalistic observation, is that concerning alcohol and traffic accidents. From this research have come mandatory breath tests for alcohol, and penalties for drunk or impaired driving; unfortunately there is little evidence that these procedures are effective. More recent investigations have moved the focus from the physiological and sensory effects of alcohol to studies of problem drinkers and alcoholics as heavy contributors to alcohol-related accidents. Again, effective countermeasures have been difficult to find. The first purpose of this paper is to outline the most prominent findings relating alcohol to traffic accidents, especially those concerned with actual alcoholism and traffic accidents. The second purpose is to explore the various measures that have been suggested for reducing the accident contribution of the alcoholic driver. The role of the alcoholic driver has been investigated from an epidemiological point of

Dr. Smart is a research scientist in psychological studies at this Foundation. He delivered this paper to a symposium on automobile safety at the annual meeting of the American Psychiatric Association in Detroit in May, 1967.

view and from a psychological one in which etiological considerations were examined. Both of these approaches are essential to a consideration of effective countermeasures, and both will be considered here.

Studies of impairment

The first research studies with alcohol were attempts to demonstrate the impairing effects of various dosages on sensory-motor functions. Although some of these studies are methodologically inadequate (Carpenter, 1959; Jellinek and McFarland, 1940), the results consistently show that most persons are impaired in visual and motor skills at blood alcohol levels above .10 per cent. Many persons show almost as much impairment at levels between .05 per cent and .10 per cent. These experiments have included studies of performance on reaction-time apparatus (Forbes, 1947; Grüner, 1955), target shooting (Newman, 1947), typing (Eggleton, 1941), handwriting (Rabin and Blair, 1953), and motor co-ordination (Pihkanen, 1957).

In addition, numerous studies of simulated driving situations have shown that almost all persons are impaired at .10 per cent with many impaired at levels around .03 per cent. Studies in simulation trainers, of course, lack many aspects of the real driving situation, such as the presence of other traffic, pedestrians, back-seat drivers, passengers, and the internal stimuli associated with movement. For these reasons, road studies of alcohol involvement in traffic are essential; and many of them do yield results that might have been expected from the experimental studies.

At least two early road surveys (Lucas, Kalow, McColl, Griffith and Smith, 1955; Smith and Popham, 1951) have found that samples of accident drivers contain higher proportions of drinking drivers than do non-accident drivers tested at the same location.

Lucas and his colleagues studied accident and non-accident drivers in Toronto and found that drivers with blood alcohol levels of .10 per cent to .15 per cent were *twice as frequent*

in the accident group as in the non-accident group. Those in the range beyond .15 per cent were eight times as frequent in the accident group. Smith and Popham found that drivers who had levels above .05 per cent were more often responsible for their accidents (in terms of driving errors) than were those with levels between .00 per cent and .05 per cent. In addition, 21 out of 22 drivers with blood alcohol levels of .15 per cent or higher were entirely responsible for their accidents. The assessment of responsibility in Smith and Popham's study was made without knowledge of the drinking status of the drivers, and hence the drinking and responsibility data were not confounded.

The latest of the drinking and driving surveys (Borkenstein, Crowther, Shumate, Ziel and Zylman, 1965), involved a comparison of a group of accident drivers in Grand Rapids with a control group of non-accident drivers matched for sex, age, location and the time of day at which they were travelling. It was found that drivers with blood levels up to .08 per cent were *less* frequently observed in the accident group than in the control group. Only at levels over .08 per cent does alcohol appear to contribute significantly to accident involvement. Surprisingly, drivers with levels between .01 per cent and .04 per cent were *less* likely to be involved in accidents than were completely sober drivers. This supports Vogel's experimental finding that low blood alcohol levels can enhance the performance of certain motor skills (Vogel, 1958). (A blood alcohol level of .04 per cent represents very moderate and well-paced alcohol consumption: if a 160-pound man were to have only two drinks and stretch them out over an hour, his blood alcohol level would probably reach about .04 per cent.)

Studies of the driver

Partly because of the high blood alcohol levels found in these surveys, research interest has shifted from surveys to studies of the drinking driver himself. It seems likely now that many alcohol-related accidents are not caused by convivial social drinkers but by alcoholics who have been drinking very

heavily. Data bearing on this question had been collected by Holcomb as early as 1938; however, the special role of the alcoholic was not directly investigated until the early 1950's. Holcomb (1938) found that 14 per cent of the drivers in his accident survey had blood alcohol concentrations of .15 per cent or above. Smith and Popham (1951) found that 22 per cent of the drinking drivers in their study had blood alcohol levels above .15 per cent. Borkenstein and his colleagues (1965) found that 19 per cent of their drinking drivers were in the "over .15 per cent" group. The highest blood alcohol levels were found in a study of fatal accidents in Manhattan; 46 per cent of the drinking drivers involved in fatal accidents during the period studied had concentrations of .25 per cent or more (McCarroll and Haddon, 1963).

Heavy drinkers

These are extremely high blood alcohol levels to be achieved in social drinking. To attain a .15 per cent level a person of average weight (160 pounds) would have to consume nine ounces of whisky within an hour; to attain .25 per cent he would have to consume fourteen ounces. Surveys of the frequency and quantity of alcoholic beverages drunk by the general population show that most social drinkers never drink as much as nine ounces at one time. In Mulford and Miller's survey of drinking habits only 19 per cent reported having drunk nine ounces at a sitting in the year prior to the survey (Mulford and Miller, 1960). What all of these drinking and driving surveys indicate is that many persons having accidents after drinking are among the heaviest drinkers in society. Their drinking prior to their accident looks more like an attempt at anaesthesia than convivial social drinking.

These conjectures have been pursued in several different types of research. One of these is concerned with determining the proportions of alcoholics or excessive drinkers in various driving populations. For example, Goldberg (1955) found that 45 per cent of all drivers convicted for drunk driving in Sweden

were alcohol addicts, alcohol abusers, or excessive drinkers, compared to only 9 per cent of the general population. Waller has also estimated (1965a) that 50 per cent of the drunk driver population could be found to be alcoholic. In an earlier study, Smart and Schmidt (1961) estimated that at least 14 per cent of the Ontario drivers convicted of impaired driving (a lesser charge than drunk driving) should appear at alcoholism clinics.

Many are alcoholics

Part of the discrepancy between the American and Swedish findings and the Canadian findings may be explained by the higher alcoholism rates in the U.S.A. and Sweden. Another possibility is that the Canadian study missed many alcoholics by including only those who had been seen in clinics. Probably no more than a third of all alcoholics in Ontario are ever seen in such facilities. There can be no doubt that a substantial number of drivers convicted of drunk or impaired driving are alcoholics rather than social drinkers. This of course, means that such drivers represent a different and highly complicated problem of enforcement.

Studies of accidents

Smart and Schmidt (1967) also determined the proportion of excessive drinkers in a sample of 97 drivers involved in accidents. It was found that 23 per cent of these drinking drivers had been seen at an alcoholism clinic or had been convicted of some offence involving alcohol (usually public intoxication). Only 8 per cent of the non-drinking drivers involved in accidents were "excessive drinkers." When the excessive drinkers and normal drinkers involved in drinking accidents were compared, several further differences implicated alcoholic drivers directly in the causation of the accidents. The excessive drinkers had an average blood alcohol level of .13 per cent, which was twice as high as the normal drinkers (only .07 per cent) at the time of their accidents. Also, a blind rating of responsibility for the accident (based on driving errors) showed that excessive

drinkers had significantly higher responsibility scores than did normal drinkers.

The .13 per cent average blood alcohol level attained by the alcoholics is, of course, well within the impairment range for most psychomotor skills, including driving. However, the .07 per cent average level for the normal drinkers is similar to the levels found in non-accident drivers in several drinking and driving surveys (Lucas *et al.*, 1955; Borkenstein *et al.*, 1965). In the Grand Rapids study by Borkenstein and his associates, only at levels above .08 per cent were drinking drivers more frequently found in the accident group than among the non-accident group. It may be that excessive drinkers are primarily responsible for those alcohol-related accidents in which alcohol is a definite causative factor.

Studies of alcoholics

Surveys such as those described above have been supplemented by special studies of the accident experience of alcoholics. Schmidt and Smart (1959) studied the accident rates of 98 alcoholic clinic patients. These alcoholics had twice as many accidents as would have been expected from the accident rates in the general population, and seven times as many convictions for drunk or impaired driving. Most of their accidents were preceded by drinking; their non-drinking accident rates differed very little from those of the general population. The results of this study have been replicated by Selzer, Payne, Quinn and Westervelt (1965) in Michigan and by Waller (1965b) in California. All three studies found that alcoholics had accident rates almost twice as high as the general population, even when corrected for exposure (in terms of miles driven per year) as in Schmidt and Smart's and Waller's studies.

The types of accidents involving alcoholic drivers have also been investigated. Schmidt and Smart (1959) found that almost all of the alcoholics' accidents were non-collision: few involved collision with other cars or pedestrians; most were accidents in which the driver ran off the road or struck a fixed object. This

might have been predicted from certain findings of a "tunnel vision" effect of alcohol; however, the low rate of collision accidents may also occur because so many of the alcoholics' accidents occur at night (Smart and Schmidt, 1967) when traffic density is low.

Several studies have shown that the alcoholic driver is also more frequently involved in fatal accidents than are other drivers. Selzer and Weiss (1965) studied 72 drivers responsible for fatal accidents in Michigan and found that "29 (40%) were alcoholic, seven (10%) were pre-alcoholic and 36 were non-alcoholic." (They defined alcoholism as "a symptom of chronic emotional illness characterized by repeated drinking in amounts sufficient to cause injury to the drinker's health or to his social or economic functioning.") Brenner (1966) added to these findings in his study of the causes of death of 1,343 alcoholics in California. He found that alcoholics were four and a half times as likely as the general population to die in a fatal traffic accident.

There is, now, an impressive amount of evidence that implicates alcoholics in all types of traffic accidents and charges involving alcohol. A clear epidemiological picture is emerging of the risk rates of alcoholics in driving. However, there is less extensive knowledge of the underlying reasons for the alcoholic's driving hazards. Many alcoholics seem to have low or normal accident rates, and we have only begun to discover the reasons for their immunity. Efforts to modify the behaviour of alcoholic drivers will clearly depend upon our knowledge of the necessary and sufficient conditions for their accidents.

Differences among alcoholics

Several studies have been made of the differences between alcoholics involved in accidents and those not so involved. Smart (1965) found that only 60 per cent of a group of alcoholic patients had been involved in an alcohol-related accident in the ten years prior to their hospitalization. It was hypothesized that the accident group would show greater extra-punitiveness (outwardly directed aggression) and greater extroversion on personal-

ity tests. It was also predicted that the accident drivers would drink more frequently, would drink away from home more often, would drive less carefully after drinking and would drive more frequently after drinking. No differences between the groups were found for the personality variables, but a number of reported drinking and driving behaviours did differ. Alcoholics who had alcohol-related accidents more frequently drove after drinking large amounts of alcohol (more than seven ounces) and they more often believed that they and others can drive just as well after drinking as when sober. As expected, they less frequently had personal rules prohibiting drinking and driving. It appears, then, that the alcoholic involved in accidents is a highly confident driver, sure of his ability to counteract the effects of alcohol but in fact unable to do it successfully.

Accident syndrome

Selzer and his colleagues also attempted to find an underlying personality syndrome among alcoholic drivers who had had accidents. They studied 50 alcoholic patients and 50 non-alcoholic patients at the University of Michigan Medical Center. Therapists made ratings for each patient on 31 questions concerning psychopathology. These ratings categorized each driver either as within normal limits or as definitely abnormal. The correlations between traffic accidents and the therapist ratings were highest for the questions concerned with paranoid ideation, depression, aggressive behaviour, and fantasy preoccupation. Unfortunately, the manner in which alcohol deepens or alleviates feelings of persecution, depression, or anger has not been investigated as yet. It may well be that these behaviours are made more prominent, or less controllable, by the alcoholic's heavy drinking. More studies are required in which interactions between personality features and alcohol effects are investigated.

Despite the recent accumulation of knowledge about the alcoholic driver, effective counter-measure techniques are difficult to suggest. It is widely recognized that we cannot expect the alcoholic to voluntarily restrict his alcohol intake, because

of his difficulties in achieving controlled drinking. This almost certainly rules out the usual public education slogans (If you drive, don't drink," etc.) from consideration. Another possibility is that alcoholics could be encouraged to seek treatment. Successful treatment would reduce their drinking and it should also reduce their accidents, since most of their accidents are preceded by heavy drinking. Efforts could be made to get the alcoholic to seek treatment voluntarily after he has had a licence suspension for drinking. Where such efforts have been made they have not been successful, because so many drinking drivers are unprepared to see their drinking as abnormal or dangerous. However, it is possible in many jurisdictions to make treatment for alcoholism a condition of licence reinstatement for the alcoholic driver. The treatment agency would then have the problem of actually involving the alcoholic in therapy rather than merely having him go through the motions for the sake of retaining his licence.

Whether the alcoholic driver would respond to enforced treatment to keep his licence is an open question. Tillman (1967) has attempted to involve a group of chronic driving offenders in a program of group psychotherapy. Many of these drivers had committed alcohol-related offences, but few were able to make use of psychotherapy to modify their driving behaviour. Most were not willing to become involved in the therapy program, and absenteeism was frequent.

Reporting before accidents

Alcoholics might also be forced to seek treatment or to modify their drinking behaviour in order to retain their licences, without waiting for them to have an alcohol-related accident. Seventeen states have laws requiring physicians to routinely report persons with chronic medical conditions to the motor vehicles department. Under the present law in California persons with epilepsy or other chronic medical conditions resulting in lapses of consciousness or of conscious control and persons convicted of possession of illegal drugs are reported to the

Department of Motor Vehicles. At that time their driving records can be reviewed and their licences suspended on medical grounds. Physicians are not required to report alcoholics; but expansion of this law might logically require them to do so—particularly since Waller (1965) has shown that drug abusers do not have higher accident rates than the general population, whereas alcoholics certainly do. Alcoholics are sometimes reported by the courts, although this is not compulsory. The Department of Motor Vehicles can revoke a reported alcoholic's licence if it believes that his alcoholism does hamper his driving ability. The number of alcoholics reported is very small—only 319 out of a total of more than 600,000 alcoholics in California (Waller, 1965b).

Problems in reporting

This procedure, of course, overcomes the alcoholic's reluctance to seek treatment, but co-operation from the reporting agencies is difficult to obtain. There is also the possibility that reporting of this sort could undermine the confidence of the alcoholic in the treatment personnel and make involvement in therapy even more difficult. A further problem is that we are uncertain whether revocation and suspension of licences does really reduce the alcoholic's accident rate. If it is combined with effective treatment for their drinking pathology it does result in a reduction, although Schmidt and Smart (1959) found that many alcoholics drove while under suspension and many had drinking accidents while legally ineligible to drive.

It must be stated that at present there is no effective counter-measure program for the alcoholic driver. In fact, few counter-measure programs of any sort are directed against high-risk drivers. Most of the accident-reducing measures are directed at changing the engineering features of roads or cars, rather than at modifying driver behaviour directly. Whether engineering changes can sufficiently modify the alcoholic's driving is uncertain at present. What many such measures do is to take the responsibility for safe driving behaviour away from the driver;

in a way, they invite him to become less vigilant, and perhaps make dangerous behaviour more frequent by lessening its possible consequences. One wonders, too, what effect safety features will have on the alcoholic driver—will he remember to attach his seat belt, or will he be too inattentive from drinking to bother? Research in a wider variety of countermeasures of direct relevance to excessive drinking should be considered, in addition to engineering changes.

On the basis of the Smart and Schmidt study (1967), problem drinkers are responsible for about 20 per cent of all alcohol-related accidents. When that figure is projected onto the number of alcohol-related accidents in the United States and Canada each year, it can be seen that thousands of accidents might be reduced in their seriousness or eliminated altogether by an effective countermeasure. This degree of accident reduction is worth a great deal more research effort than has been expended so far.

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Summer Course, 1968

The Addiction Research Foundation of Ontario will offer its seventh annual summer course on Alcohol and Problems of Addiction at Laurentian University, Sudbury, in co-operation with the university. The two-week residential course begins June 2nd and ends June 14th, 1968.

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The course is designed to provide basic information for those who are called upon in their professional work to deal with problems related to the misuse of alcohol and other drugs. It is planned especially for those who are engaged in developing and supervising programs that aim at reducing such problems wherever they may occur.

Enrolment is limited to eighty, and priority will be given to applicants in public administration, industry, medicine, nursing, social work, education, the law and the clergy.

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Clinical Reduction of Smoking:

A California Study

By Jerome L. Schwartz, Dr.P.H., and
Mildred Dubitzky, Ph.D.

Cigarette smoking plays an important part in the causation of a wide variety of diseases—especially disabling and fatal respiratory disease, heart conditions and ulcers.¹⁻³ The U. S. Public Health Survey has gathered evidence that cigarette smokers suffer ill health from chronic and acute disorders to a much greater extent than non-smokers.⁴ Cigarette smoking by pregnant women has been shown to affect the growth and development of the embryo, the fetus and the child.⁵

The accumulation of evidence relating cigarette smoking to ill health was emphasized in a comprehensive report by the Surgeon General's Advisory Committee, published in 1964. The report concluded that: "Cigarette smoking is a health hazard of sufficient importance in the United States to warrant appropriate remedial action."⁶ The California State Health Department also issued a statement on smoking and health,⁷ which was followed by a report in 1964 by the Governor's Advisory Committee on Cigarette Smoking. The Governor's report reviewed action programs and outlined approaches to the prevention and control of cigarette smoking.⁸

The latter report concluded that withdrawal clinics are the most promising method for aiding many smokers who are unable to give up the practice by themselves. It urged that a clinical program be organized, tested first on a pilot basis, and then, if successful, instituted statewide.⁹

The study reported here, conducted by the Smoking Control Research Project, was designed to evaluate various methods of

Dr. Schwartz is project director and Dr. Dubitzky is research psychologist for the Smoking Control Research Project at Berkeley. Dr. Schwartz is also lecturer in social welfare at the University of California, Berkeley. This article first appeared in *California's Health*, Vol. 24, No. 6, February, 1967, Pages 78-84, and is reprinted by permission. Additional figures on the one-year follow-up (see table, Page 38) were supplied by Dr. Schwartz.

helping people to give up cigarettes. Further aims of the study were to investigate psycho-social aspects of smoking behaviour such as the differences between smokers willing and unwilling to participate in smoking control methods; the factors that sustain cigarette smoking behaviour, or prevent recidivism (reverting to the habit); and the nature of the smoking change process itself.

Three methods tested

Three smoking withdrawal methods were tested in the present study: tranquillizers, individual counselling, and group meetings. These methods are frequently employed to aid and foster behaviour change, although no previous study has determined their effectiveness in smoking cessation under controlled conditions. This paper presents the results of the methods at the end of the treatment program and after a four-month follow-up.

The study began in the fall of 1965 with a survey questionnaire mailed to 8,284 male members, 25 to 44 years old, of the Kaiser Foundation Health Plan in Walnut Creek. Those respondents who smoked at least ten cigarettes daily and indicated that they were either concerned about their cigarette smoking or might want to stop were invited to participate in withdrawal methods. The design called for 324 subjects—36 each in seven different treatments and two control groups.

All subjects (except those in the first control group) completed psychosocial questionnaires and were medically screened by an internist.

Subjects were randomly assigned to withdrawal methods and to a Treatment Control group. At the same time, assignments were made to tranquillizer and placebo combinations within each method. The tranquillizer used in this study was Equanil (meprobamate, 400 mg.); the placebo was identical in appearance to the tranquillizer.

Socio-economic status was controlled by classifying each individual in one of three social class groupings before assignments were made. Classification was based on the Hollingshead two-

factor index of occupation and education,¹⁰ modified by taking income into account.

The first control group of 36 males was selected from among individuals who had made appointments for Intake and were therefore considered willing to take part in the program. This group served to measure both the effects of the questionnaire and of the invitation to participate. The second control group was assigned at the same time as subjects were assigned to treatment methods, and therefore represented a control on the effects of the treatment methods themselves.

Basically, three different methods were compared, all lasting eight weeks: Prescription (medication alone); Individual Counselling with medication; and Group Meetings with and without medication. All subjects, regardless of method, received a written orientation guide and a list of "tips" to aid them in their effort to stop smoking. They were also offered literature, movies on the health dangers of smoking, and special dietary information.

Assignment to methods

Seventy-two subjects were randomly assigned to the Prescription method, half of them receiving tranquillizers and half placebos, with an equal number of subjects from each social class. Participants received their pills at two-week intervals from the Health Plan pharmacy.

The Individual Counselling method involved weekly twenty-minute meetings with a trained counsellor. Again, half of the 72 people assigned to this method received tranquillizers, half placebos.

The situation was somewhat more complicated for the Group method. Here subjects met once a week in groups for 1½ hours at a time, with a trained psychologist. Half of the individuals in each of six groups had tranquillizers, the other half placebos. Three of the groups had no pills at all.

All Individual and Group counsellors saw equal proportions of persons in each social class and in each pill category (tranquillizer and placebo).

Success Rates for All Methods and Controls

	Total Number	Successful at End of treatment		Successful at 4-Month Follow-up		Successful at One-Year Follow-up*	
		Number	(Per Cent)	Number	(Per Cent)	Number	(Per Cent)
Total treatments	252	83	(32.9)	52	(20.6)	51	(20.2)
Prescription	72	16	(22.2)	13	(18.1)	12	(16.7)
Placebo	36	10	(27.8)	9	(25.0)	9	(25.0)
Tranquillizer	36	6	(16.7)	4	(11.1)	3	(8.3)
Individual Counselling	72	30	(41.7)	17	(23.6)	16	(22.2)
Placebo	36	18	(50.0)	10	(27.8)	11	(30.6)
Tranquillizer	36	12	(33.3)	7	(19.4)	5	(13.9)
Group Meetings	108	37	(34.3)	22	(20.4)	23	(21.3)
Group-Pill	72	29	(40.3)	17	(23.6)	17	(23.6)
Placebo	36	17	(47.2)	12	(33.3)	10	(27.8)
Tranquillizer	36	12	(33.3)	5	(13.9)	7	(19.4)
Group-No Pill	36	8	(22.2)	5	(13.9)	6	(16.7)
First (Questionnaire) Control	36	4	(11.1)	4	(11.1)	4 ^a	(11.1)
Second (Treatment) Control	36	4	(11.1)	3	(8.3)	4 ^a	(11.1)

* Results after one year of treatment showed little change from the four-month follow-up. Of the 252 subjects in all treatment groups, 51 (20.2 per cent) were still successful after one year—a loss of only one subject from the four-month follow-up. In addition, 73 (29.0 per cent) reduced their smoking and 128 (50.8 per cent) did not change their smoking habits.

^a At the one-year follow-up, there were actually 13 successes in the control groups, but some of them had been smoking at the four-month point. To find the number of controls not smoking for at least eight months, another follow-up was conducted, the results of which are shown above.

Subjects in all methods were asked to keep daily records of their smoking (cigarettes, pipes, and cigars) and their pill consumption. In addition, Counselling and Group subjects filled out attitude, mood, and personality inventories at various intervals during the program.

End-of-treatment results

The results of the smoking control program are presented in the table. It can be seen that of the total experimental sample (252 subjects), 83, or one-third, are classified as successes—i.e., reduced their cigarette smoking by 85% or more. (In fact, all but nine stopped smoking entirely.) This figure compares with 11.1% success for each of the control groups. (Two-fifths of the experimental subjects reduced their smoking, and one-fourth showed no reduction or a slight increase.)

Differences among treatment methods in rate of success can also be seen. The four Counselling-Pill combinations showed significantly higher rates of success compared to the controls, but the two Prescription combinations and Group-No Pill did not.

When the various experimental techniques are compared, we note that only 22.2% of the persons assigned to Prescription and to Group-No Pill were successful, as compared to 41.7% for Individual Counselling and 40.3% for Group-Pill.

Counselling more effective

Individual Counselling was significantly more effective than Prescription only and Group-No Pill; furthermore, Group-Pill produced higher rates of success than the Prescription method and somewhat higher than Group-No Pill. None of the other differences was significant. Thus, the Counsellor-Pill combinations are fairly close in rate of success. Prescription and Group-No Pill appear to be less effective.

These results may be expressed in a different way, in terms of the distribution of the 83 successful cases. The placebo combinations for Individual Counselling and Groups each supplied

one-fifth of the successes, whereas the tranquillizer approaches for these methods accounted for only one-seventh of the successes.

Class variations

Certain variations were noted among the three social class groupings. For all treatment methods combined, the lower-class subjects were most successful (40.5%), followed by the upper-class subjects (30.6%) and the middle-class (27.7%). The lower-class subjects responded best to both Prescription methods, but also did well in Individual Counselling-Placebo, and Group-No Pill.

The upper-class subjects actually did better than the middle- and lower-class subjects in the Group method *when pills were used*. Also, middle-class subjects were superior in the Individual Counselling-Tranquillizer treatment.

In the Group method, the over-all rates of success varied from 51.4% for one counsellor to 25.7% and 24.2% for the other two. These differences are significant at about the .03 level. Although there were differences in success rates among individual counsellors, these were not significant.

Use of the pills seemed to exert some effect upon the results of the various treatment methods. For example, only about one in five Group-No Pill subjects was successful. In comparison two of five Counselling-Pill subjects were able to stop smoking.

The type of pill used was of some importance. Placebos were found to be consistently more effective than tranquillizers in each method. Perhaps this may be explained by the occasional development of annoying side-effects from the tranquillizers such as drowsiness and sensitivity to alcohol. The effect of the drug may have been detrimental to the subject's own determination to stop smoking. Analysis of data to determine the extent to which both kinds of pills were actually taken, the subject's attitudes toward the medication, and other factors, is being done and should yield results bearing on this question.

Four months after the end of the program, all treatment

subjects and controls were re-evaluated in terms of the number of cigarettes they were currently smoking. Subjects were divided into categories based on their change in daily cigarette smoking between the time of the survey questionnaire and the four-month follow-up.*

At the four-month follow-up, 52 (21%) of the subjects were successful, compared to 83 (33%) at the end of treatment. (See table.) Forty-nine of the 83 subjects who were successful by the end of the eight-week program were still rated as successful. Two subjects who had previously reduced their smoking were now not smoking at all; and one prior failure had become successful.

Most of the recidivists (former successes who resumed smoking) were now in the "failure" category (less than 15% reduction in the daily number of cigarettes smoked), but some were still in the "slightly reduced" category.

Half of the subjects were failures at follow-up, compared to one-fourth at the end of treatment.

Control successes

Eight controls were successful at end of treatment, 7 at follow-up. The percentage of controls in the failure category declined (the reverse was true for treatment subjects), indicating that some of the controls reduced their daily cigarette consumption on their own.

Differences in success at the end of treatment and follow-up were also noted. (See table.) Losses between the two points varied from 0 (Control I) and 10% (Prescription-Placebo) to as much as 58% (Group-Tranquillizer) and 42-44% for the two Individual Counselling combinations. The Group-Placebo combination lost 29%; Group-No Pill, 36%; and Prescription-Tranquillizer, 33%.

The placebo combinations still appear to show the best results. Groups with placebos were significantly more effective than

*Information on the one-year follow-up arrived after the body of this article had been set in type, but is incorporated in the table on Page 38.—*Ed.*

the controls and the prescription-tranquillizer combination.

The follow-up results indicate that overall the methods employed were not significantly better than the controls in helping people to give up smoking *on a long-term basis*. Only groups with placebos, having a success rate of one-third, were appreciably superior to the other techniques. The counselling-pill combinations had initially shown promise, but by follow-up 40% of the successful subjects in these methods had gone back to smoking cigarettes.

Abstinence not sustained

Apparently, then, the methods employed were not sufficient to *sustain* abstinence. Thus, either the treatment should be intensified (e.g., more frequent meetings), or the methods should be reinforced by continued contacts, a buddy system, etc.

The high number of drop-outs among group members around the sixth week argues against the advisability of lengthening the treatment period.

The Smoking Control Research Project has collected a mass of data relating to the 324 subjects in all treatment and control groups. Psycho-social variables, demographic data, and environmental influences are now being studied.

Subjects successful at the end of treatment and still not smoking at the four-month follow-up are being compared with recidivists and failures.

Preliminary results indicate that successful subjects are lighter smokers (10 to 15 cigarettes per day) and exhibit lower degree of anxiety than heavier smokers.¹¹ It has also been noted that successful subjects are more likely to have wives who do not smoke.

In summary, 50% of the subjects reduced their smoking by at least half, and one-third were able to reduce the number of cigarettes smoked at least 85% at the end of the eight-week program. By the four-month follow-up, the success rate had decreased to about 20%. Perhaps unexpected was the finding that more of the lower-class subjects were able to stop smoking

by the end of treatment, than were the middle- and upper-class subjects, though this difference was not statistically significant. However, the greatest losses occurred among the lowest social class, so that by follow-up the upper-class subjects had the highest rate of success.

Considering that the Prescription-Placebo combination achieved a 25% success rate at follow-up—better than three of the counselling combinations and almost as good as the other two—this “method” emerges as one that deserves further consideration. Moreover, it was by far the simplest and least costly technique employed.

In fact, subjects taking the placebos actually stopped smoking on their own, the only intervention being the knowledge that they were taking a pill and were part of an organized research program.

Questionnaires effective

Even the first control group—persons who merely received and completed a detailed questionnaire about their smoking—achieved results similar to those of subjects in groups (meeting 8 weeks for 1½ hours) with either tranquillizers or no pill.

Perhaps a low-cost method could be undertaken by local health departments or cancer societies to mail questionnaires to smokers. Simply making smokers more aware of their behaviour in this way might provide a stimulus to some of them—even if only 10%—to stop smoking on their own.

These results should not be interpreted to mean that intervention by professionals is not indicated. On the contrary, persons entering the program were more successful than controls who did not know they were part of a study.

The fact that placebos helped many subjects to give up smoking would seem to indicate that if a “pill” could be developed that would combine the “placebo effect” with a medication that really helped smokers in some way to give up cigarettes, smoking control techniques might improve.

Additionally, an atmosphere of non-smoking in the subject's

home, place of work, and community, along with the intervention of professionals and the encouragement of "those who care," would likely be helpful adjuncts to therapeutic methods designed to change smoking behaviour.

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A.I.T. Addictions

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Authorized as second class mail by
the Post Office Department, Ottawa,
and for payment of postage in cash.

A.I.T. Addictions

Volume 15, Number 1

Spring, 1968

Marihuana and its Effects: An Assessment of Current Knowledge

**A statement from the office of the Executive Director,
Addiction Research Foundation of Ontario**

It is misleading to discuss the use of individual drugs, such as marihuana, outside of the context of our society's prevalent views and practices with respect to all substances that affect a person's mood and behaviour. The choice of any particular drug by any one segment of the population at any given time is generally less significant than the underlying personal and social reasons for the use and misuse of drugs. Marihuana is currently the object of much concern in our society, even though the misuse of alcohol and certain other drugs, especially the barbiturates, constitutes a much greater problem in terms of both the known number of people who habitually misuse these drugs and the known possibilities of serious functional or organic damage to the excessive user. The fundamental problem arises from the fact that

Material for this statement was provided primarily by Dr. O. J. Kalant, Research Scientist (Biological Studies), and Dr. Harold Kalant, Associate Research Director (Biological Studies), of this Foundation.

many people habitually use one drug or another for inappropriate purposes and thereby run some risk of doing harm to themselves, to others around them, or to the society they live in.

Acute effects

The acute effects of marihuana, like those of any other drug, depend on the dose administered and the person to whom it is administered. There are now available a number of good observations of the effects of marihuana on reasonably large groups of subjects. With the usual dose, the effects on most subjects are mild and are characterized principally by euphoria, heightened intensity of visual and auditory sensations, and a tendency towards passivity and relaxation.

However, a few individuals in any large group do appear to show adverse reactions characterized by anxiety or panic. Several observers conclude that the difference in effect depends essentially on the mental state of the user and the setting in which the drug is taken. There is no evidence that the use of the drug in itself causes crimes of violence or antisocial behaviour, although it is known that any drug that disturbs inhibitions may have such consequences in some persons, depending on their repressed drives and conflicts.

Comparisons between marihuana and alcohol are meaningless unless dose and circumstances are considered. It seems clear that the amount of marihuana normally used is not followed by any hangover or other physical impairment. One must point out, however, that under the usual conditions of social use, alcohol also is not followed by any ill effects. The duration of effect produced by a single marihuana cigarette is highly variable, depending on the quality of the preparation and the individual manner of use, and may range anywhere from half an hour to eight hours. The risk to the user is very small if the drug is taken in a situation

in which others are on hand to protect the individual from all effects. However, the distorted perception of time and space that results from even mild doses could constitute a hazard in driving, essentially no different from the hazard produced by a sufficient amount of alcohol.

Since the use of marihuana is illegal in this country, while that of alcohol is permitted except for persons under some specific age, differences between the segments of the population that use these different drugs may complicate any comparison of their behavioural effects. Most reported studies suggest that marihuana is used mainly by lower strata of society and, more recently, by youthful protesters against authority. However, this selection factor may be changing: there have lately been press reports of increasing use of marihuana by adult members of conventional middle-class groups.

Chronic effects

The information currently available about the chronic effects of marihuana use is not nearly as complete or conclusive as the information about the acute effects. It is generally agreed that chronic marihuana users may discontinue the drug without any risk of physical withdrawal symptoms. Despite the frequent statement that the drug creates no craving or severe psychic dependence, there are good case descriptions of persons who need to maintain a state of marihuana intoxication for most or all of their waking period and whose social functioning is impaired without it. This constitutes drug dependence as defined by the World Health Organization. It should be recognized, however, that dependence is not necessarily bad in itself, either for the individual or for society. The question to be evaluated, therefore, is not whether dependence can occur, but whether dependence in a given case results in physical, psychological or social harm.

There is not enough information about the effects of

marihuana on chronic users to permit a reasonable conclusion. The studies by the Chopras in India and by Benabud and Roland and Teste in North Africa, and the collections of case reports by Moraes Andrade, Lucena and others in Brazil, are among the most thorough available to date; but they all suffer from the lack of suitable matched control populations of non-users for comparison. This does not invalidate all their conclusions: the studies by the Chopras included groups of subjects using different doses and different preparations of hemp; and when differences in effects can be correlated with differences in doses, preparations or methods of administration, certain reasonable inferences can be made about the action of the drug. On this basis it seems clear that chronic smoking of hemp preparations may give rise to chronic lung damage, but this may be due to non-specific irritants in the smoke rather than to cannabis principles themselves.

Chronic deteriorated users

Some governments, especially those of Egypt, Morocco and Brazil, are deeply concerned about the association between widespread use of cannabis preparations and deterioration, both physical and social, in large segments of their populations. Some observers suggest that the habitual use of large doses of potent cannabis preparations such as hashish results in a state of inactivity that impairs the user's ability to attend to his physical and social requirements and leads to defective nutrition, diminished resistance to infection, and social ineffectiveness.

However, other observers dispute this interpretation and suggest that it is the low social and economic status of many chronic users that leads both to their physical and social deterioration and to their heavy use of cannabis. No valid conclusion about the harmfulness or harmlessness of chronic marihuana use can be drawn at present, particularly with respect to the pattern of use in North America. Extensive

studies are required, taking into full account the doses, preparations and modes of use, and the individual characteristics and histories of the users.

Marihuana and other drugs

Again, there is not enough well-documented evidence about the relation between the use of marihuana and that of other drugs. Those who strongly oppose its use point to the high proportion of narcotic addicts who have previously taken marihuana. This is not a logical association to make, since narcotic addicts have usually experimented with many other drugs. The important question is not what proportion of narcotic addicts have used marihuana, but what proportion of marihuana users go on to use narcotics.

Sound information on this question is not available, but the possibility of a significant connection cannot be rejected. Studies performed in other countries, or thirty years ago on this continent, suggesting that relatively few marihuana users progress to the use of narcotics, are not necessarily valid at the present time. The change in popular attitude towards marihuana may have altered the interest of professional drug vendors because of a change in the economic significance of the market. Current press reports, indicating that marihuana users now constitute a sufficiently large market to be of interest to narcotic vendors, cannot be dismissed without investigation.

Marihuana and alcohol

The claim advanced by some advocates of marihuana, that its use abolishes the desire for alcohol and other drugs, is invalid. There are many descriptions available of people who use both marihuana and alcohol, as well as other drugs; and there is no doubt that some of the other drugs that appear to be used with increasing frequency by marihuana users—such as the amphetamines and LSD—can be very dangerous indeed. Still to be evaluated is the more moderate

claim, often made, that the use of marihuana can prevent harmful dependence on alcohol and other drugs.

Conclusion

The consequences of the use of marihuana by a fairly broad segment of the population are not intrinsically different from the consequences of the use of other drugs capable of modifying the mental and emotional state of the user—for example, beverage alcohol. Some subjects will be adversely affected, and others will not. Adequate knowledge about the importance of individual differences in users, the effects of different doses, and the circumstances and duration of chronic heavy use, are essential to any scientifically valid conclusion about the effects of the drug on society as a whole. Most of this information is not yet available.

Most of the problems associated with the occasional moderate use of marihuana arise not from its pharmacological actions, but from the fact that possession of the drug is illegal. It is probably undesirable to subject users of marihuana to the severe penalties that are provided in the narcotics control legislation. However, it would also be undesirable to legalize the sale and use of marihuana unless the questions raised above can be satisfactorily answered.

Finally, problems that may arise from the chronic heavy use of marihuana should be seen and dealt with as part of the problem of drug abuse in general.

(Cet énoncé, qui nous vient du bureau du directeur général de cette Fondation, évalue l'état actuel des connaissances scientifiques au sujet de la marihuana. Il conclut que, pendant qu'il est probablement peu désirable de soumettre les usagers de cette drogue aux sévères pénalités prévues sous la présente législation pour le contrôle des narcotiques, il serait aussi indésirable de légaliser la vente et l'usage de cette drogue à moins que certaines questions puissent être répondues d'une façon satisfaisante: en particulier, l'importance des différences individuelles chez les usagers, les effets de différents dosages et les circonstances et la durée de l'usage chronique en grande quantité.)

ARF Research on Marihuana

This Foundation is currently undertaking the following research projects related to marihuana:

—An epidemiological study of drug use in the school system of Metropolitan Toronto. This is a large-scale study, designed to obtain an accurate picture of the patterns of use of various drugs among high-school students.

—A clinical study of a number of marihuana users by a medico-social team in the Foundation's out-patient department in Toronto.

—A series of psychological interviews with volunteers from among users of marihuana and other hallucinogens.

—An ethnographic study of the drug-using sub-culture in Toronto.

—An extensive critical review of the scientific literature on marihuana.

—A series of animal studies to measure the effects of pure THC (Tetrahydrocannabinol, the active ingredient in marihuana).



U.S. Laws on Alcoholism

By Robert F. Reid, Q.C.

The public is becoming aware that North American society is suffering from an epidemic of alcoholism and drunkenness problems. In the United States a number of events have recently driven the point home. To begin with, in early 1966 there were the landmark decisions of higher courts that chronic alcoholism was a valid defence to a charge of public drunkenness: the *Easter*¹ and *Driver*² decisions. These decisions have completely reversed the prior law. They rest partly on the ground that imprisonment of an alcoholic is a "cruel and unusual punishment" contrary to the Constitution; but, more importantly for Canadians, they also rest on the ground that chronic alcoholism is a disease—that the chronic alcoholic drinks involuntarily and that therefore *mens rea*—criminal intent—is lacking. A sick person, it has been held, may not be convicted merely for exhibiting a symptom of his disease in public; therefore, no chronic alcoholic may be convicted for his public intoxication. "One who is a chronic alcoholic cannot have the *mens rea* necessary to be held responsible criminally for being drunk in public."³

These decisions forced an immediate crisis. No longer could the public drunk be simply arrested, jailed and released in the familiar, futile "revolving door" process. But the courts had given recognition to a massive public-health problem before the public-health authorities had done so; and the latter, left without precedent or experience, by and large failed dismally to respond. The result was that the

Mr. Reid is counsel to this Foundation. This article is adapted from part of a paper that appeared in the *University of Toronto Law Journal* (Vol. XVIII, No. 1, 1968) under the title: "Alcohol: Problems and Recent Legislation." We suggest that lawyers especially might be interested in reading the complete article, which is available in reprint form from the Research Division of this Foundation at the address on the inside front cover of this magazine.

chronic drunkenness offender became truly homeless: the jail could no longer harbour him, and he had no place else to go. While he drifted in limbo, mounting criticism was levelled at the public-health authorities.

At this point appeared the two presidential reports—historic documents in the study of crime and its handling in the United States.⁴ These reports, and the sustained criticism of the public-health authorities by influential and dedicated people interested in reform, led to the introduction in the House of Representatives in April, 1967, of a bill providing broad measures for dealing with public drunkenness and alcoholism in the District of Columbia; and, in May, in the Senate, the introduction of a bill patterned after the House bill and intended to accelerate the provision of facilities for handling alcoholics and drunkenness offenders as health problems.

“A model program”

In the result, virtually the same bill was introduced in both House and Senate, in order to meet, in the words of Senator Tydings, “the crisis that now exists,” and to establish in the District of Columbia, in the words of his bill, “a comprehensive model alcoholism program to which other communities may turn for study, guidance and advice.” In April, a bill was introduced in the Senate to provide federal incentives to all states, to assist them in establishing facilities for handling the problem as a public-health matter. Clearly, Congress could not be accused of the tardiness that was said to afflict the public-health authorities.

The proposals for the District of Columbia are detailed and lengthy, and not susceptible of concise summary. In general, they provide for the establishment of a Bureau of Alcoholism Control in the Department of Public Health to supervise a diagnostic and treatment program that would include detoxification (sobering-up) centres and long-term in-patient and out-patient services. A person found drinking

or drunk in public or committing a misdemeanour involving alcohol (disorderly conduct, damage to property, etc.) may be subject to a variety of procedures. He may simply be taken home, or he may be taken to a detoxification centre and released when sober. If diagnosed by physicians as a chronic alcoholic, he may be committed for treatment: for up to thirty days if he is considered a danger to himself only, or for the maximum period of incarceration provided for the offence charged if he is considered a danger to others. He must be released when appropriate, and is entitled to periodic review if detained. Every effort is to be made to deal with alcoholism as a sickness and to induce the afflicted to cooperate. The provision of adequate facilities and an adequate program is positively required.

Assist state governments

The Javits-Moss bill provides for the establishment of a Bureau of Alcoholism Care and Control within the Public Health Service to conduct research and assist state and local governments in establishing programs for treatment and rehabilitation of alcoholics. It would establish an eighteen-member "National Advisory Committee on Alcoholism Care and Control" consisting of private persons who are skilled in medicine, psychology, government, law enforcement, social work, public health, or education, "or who have demonstrated particular interest in the special problems of alcoholism." This committee is to oversee the administration of the act, approve grant programs and maintain familiarity with other programs, and to report at least annually to the President and Congress. Grants rising to some \$835,000 a year by 1970 are contemplated.

Awareness of the failure of traditional methods and the need for something new is not confined to Canada and the United States. It is evident also in England, where the Criminal Justice Bill, only recently passed, is intended to secure that the offence of being drunk and disorderly shall no

longer be punishable by imprisonment. It is provided that this amendment may not be brought into force until sufficient suitable accommodation is available for the care and treatment of persons convicted of this offence.

It is apparent that many changes might be made in the American proposals; more detailed examination should thus await their ultimate enactment. The significant aspect of these proposals is that they put into effect the basic proposition on which most authorities agree, that laws making public drunkenness *per se* an offence should be repealed.⁵

It is also worthy of note that none of the measures proposed or enacted deal directly with the problem of the non-public alcoholic, whose affliction must mean social loss and private grief of a similar order to that which surrounds the public drunk. In time, this problem must also be tackled, difficult and delicate as it is. On the occasions when the problem has been tackled in the past—and the history of attempts is very long—little success appears to have been achieved. Various reasons may be assigned, including the cost and uncertainty of civil commitment proceedings, the fear of retribution on the parts of wives and friends, the attitudes of judges who tended to regard the proceedings as an interference with civil liberties, and the understandable reluctance of judges to recommend commitment to mental institutions with no guarantee of treatment.

Break with the past

In dealing with problems of alcoholism and drunkenness, regional differences may require somewhat different action. But, these aside, a complete break with the past is clearly called for. The failure of traditional methods is abundantly clear. But no matter how pressing the need for change may be, those who have studied the problem closely are aware that more might be lost than gained through precipitous action or through failure to analyse the problem correctly or to act courageously enough.⁶

It is thus well to bear in mind how broad and deep the change in methods and institutions must be, if the problem is truly to be treated as a public-health problem in future and not, as in the past, simply one of public order. In Pittman's words, "it is improbable that any single type of after-care facility can adequately assist all . . . alcoholics."⁷ The necessary steps include training programs for police, the immediate medical evaluation of all persons suspected of public intoxication to prevent needless deaths from inattention, and the establishment of detoxification stations to which police would take persons apparently under the influence of alcohol instead of taking them to jail. A program of referral of the alcoholic from detoxification stations to other community resources for long-term treatment is essential. The diversity inherent in chronic drunkenness cases requires a diversity in aftercare treatment. Six kinds of facilities are needed: out-patient clinics, domicil-aries, community houses, half-way houses, foster homes, and social centres.

Diversity in aftercare

The need for such diversity in the aftercare program is explained by Pittman:⁸

The aftercare program must employ a multitude of different approaches for the following reasons:

The etiology of alcoholism is unknown. Therefore there is no single variable to which one type of aftercare treatment can be addressed. Rather there are numerous variables with which one type of aftercare facility would find it impossible to contend.

The term, "alcoholism," encompasses a diversity of subtypes of the disease. Jellinek, for example, suggested five different types of alcoholism. Different types of aftercare facilities would handle various types of alcoholism.

Some alcoholics, because of greater mental and physical deterioration, will need more supervision than alcoholics who stopped their drinking at an earlier stage in the disease process.

The personal and social resources of alcoholics are different. For example, education, job experience, age, and health vary greatly

among alcoholics, and as a result some will be able to increase the level of social functioning more readily than others.

The President's Commission on Law Enforcement and Administration of Justice sums up the requirements as follows:

1. Drunkenness should not in itself be a criminal offence. Disorderly and other criminal conduct accompanied by drunkenness should remain punishable as separate crimes. The implementation of this recommendation requires the development of adequate civil detoxification procedures.

2. Communities should establish detoxification units as part of comprehensive treatment programs.

3. Communities should coordinate and extend aftercare resources, including supportive residential housing.

4. Research by private and governmental agencies into alcoholism, the problems of alcoholics, and methods of treatment should be expanded.

Alcohol is a tricky substance. In its social aspect it discloses some of its chemical properties. An alcohol fire cannot be put out with water, and the social fires that are fed by alcohol cannot be stopped with watered-down legislation. The lesson of the past is clear: legislation that fails to ensure a truly comprehensive program and to provide the facilities to make it effective has little hope of success in combating the whole problem of alcoholism and drunkenness. There is no quick or easy solution, and half-measures may be worse than none at all.

Notes

¹ *Easter v. District of Columbia*, 361 F 2d. 50, a decision of the United States Court of Appeals for the District of Columbia Circuit, decided March 31, 1966.

² *Drinn v. Hinnant*, 356 F 2d. 761, a decision of the Court of Appeals for the Fourth Circuit, handed down shortly after *Easter* was argued.

³ *Easter* (see note 1), *per curiam*. The defence does not appear to have been raised successfully in Canada. On the subject of *mens rea*

as it has been applied to the intoxicated offender in general, see S. M. Beck and G. E. Parker, "The Intoxicated Offender: A Problem of Responsibility," *Can. Bar Rev.*, 44, 563, 1966, and as to its application to alcohol-related and addiction-related crimes in general see E. R. Alexander, "The Criminal Responsibility of Alcoholics and Drug Addicts in Canada," *Sask. Bar Rev.*, 31, 71, 1966 (reprinted in *Addictions*, Winter, 1966).

⁴ These studies were made by the President's Commission on Crime in the District of Columbia and the President's Commission on Law Enforcement and Administration of Justice. These commissions reported, respectively, in January and February, 1967. The latter report was published under the title *The Challenge of Crime in a Free Society* and is an essential document in the literature on that subject. The parts of both reports dealing with alcoholism and drunkenness have since been grouped together and published, along with supporting studies, as the *Task Force Report: Drunkenness*, obtainable from the Superintendent of Documents, United States Government Printing Office, Washington, D.C. On this most valuable document this discussion draws freely.

⁵ Public intoxication is a crime in almost every jurisdiction in the United States and is still an offence in England, although there the law is invoked only when the offender is incapable of taking care of himself. The President's Commission on Law Enforcement "seriously doubted" that drunkenness alone (as distinguished from disorderly conduct) should be treated as a crime, but recognized the usefulness of so treating it as long as no alternative sanction exists to justify taking into custody and treating those now arrested as drunks. In the result, the commission recommended that drunkenness should not be in itself a criminal offence. This view does not, of course, suggest that the mere removal of public drunkenness from the roster of crime is, by itself, sufficient to cure the problems of alcoholism or drunkenness.

⁶ The past is littered with simple, wrong-headed solutions that have failed. See, for instance, the Ontario legislation, on the statute books in various forms for over a hundred years, authorizing municipalities to establish institutions "for the reclamation of habitual drunkards." Mayors, magistrates and justices of the peace are authorized to commit drunkards to such an institution, "with or without hard labour." No test of habitual drunkenness is given, and charge and trial are apparently unnecessary. (The Municipal Act, R.S.O. 1960, c. 249, s. 376.) In its original form it applied to "all such as spend their time and property in public houses to the neglect of any lawful calling." These, along with "idiots, lewd persons and do-

nothings," were committed to the workhouse. The idea of an institution for reclamation appeared in the statute in 1888. Its failure may be attributed to the lack of any perception that it might not be possible to achieve reclamation by force.

² What follows is based on Pittman, David J., "Public Intoxication and the Alcoholic Offender in American Society," *Task Force Report: Drunkenness* (see note 4), Page 18—a useful summary of requirements, which would probably gain general support.

³ *Ibid.*

Developments: *Powell v. Texas*

The decisions in the *Driver* and *Easter* cases were both by circuit courts of appeal; neither case was taken to the Supreme Court of the United States. However, a case involving the same principles has been appealed to the U.S. Supreme Court, and the decision will either confirm or nullify the circuit courts' rulings in *Driver* and *Easter*.

This case is that of Leroy Powell, who was convicted in Austin, Texas, of being drunk in a public place. On appeal to county court, a new trial was held, at which his conviction by the lower court was upheld and his fine increased to \$50 from \$20.

The county court made the following findings of fact, as reported in *The Municipal Court Review*:

"1. That chronic alcoholism is a disease which destroys the afflicted person's will power to resist the constant, excessive consumption of alcohol.

"2. That a chronic alcoholic does not appear in public by his own volition but under a compulsion symptomatic of the disease of chronic alcoholism.

"3. That Leroy Powell, defendant herein, is a chronic alcoholic who is afflicted with the disease of chronic alcoholism."

However, the court also made the following finding of law:

"The fact that a person is a chronic alcoholic afflicted

with the disease alcoholism, is not a defense to being charged with the offense of getting drunk or being found in a state of intoxication in any public place under Art. 477 of the Texas Penal Code."

With the issues thus defined, the defence filed an appeal with the U.S. Supreme Court, presenting the question: "Whether the conviction of a chronic alcoholic for being in a state of intoxication in a public place violates the Eighth and Fourteenth Amendments to the United States Constitution." (The Eighth Amendment prohibits "cruel and unusual punishments;" the Fourteenth applies the Eighth to the laws of each State.)

Groups present brief

The Municipal Court Review comments: "This is perhaps one of the most important cases ever to be decided in the Supreme Court of the United States affecting one of the significant problems with which the lower courts . . . must deal." Peter Barton Hutt, the successful counsel in the *Driver* and *Easter* appeals, will appear for *amici curiae* (friends of the court) in the *Powell* appeal. Parties to the *amici curiae* brief are the American Civil Liberties Union, the American Medical Association, the Correctional Association of New York, the Methodist Board of Christian Social Concerns, the North American Association of Alcoholism Programs (of which this Foundation is a member), the North American Judges Association, the North Conway Institute, the Texas Commission on Alcoholism, and the Washington, D.C., Area Council on Alcoholism.

The *Driver* and *Easter* decisions and the *Powell* appeal stimulated much thought and discussion about the role of the court with alcoholics. One point of view on the implications of these cases is expressed in the article that follows.

The Court's Changing Role

By Judge Lyle H. Truax

If *Leroy Powell v. The State of Texas*, now in the United States Supreme Court, follows the holding of the lower courts in the *Driver* and *Easter* cases, misdemeanor courts will face one of their greatest challenges. The ruling that chronic alcoholics cannot be jailed on drunk charges, in the *Driver* and *Easter* decisions, causes many judges concern as to their role with alcoholics. If the Court follows these holdings in the *Powell* case, then a reappraisal must be made of the lower courts' role.

Many will say that the courts should not accept any responsibility for treating or helping alcoholics with their problem. Peter Barton Hutt, the young attorney who piloted the *Driver* and *Easter* cases through the courts, is definite in his contention that courts should not be involved in programs to help alcoholics. He contends that forcing treatment upon alcoholic defendants violates the theory of these decisions. If a chronic alcoholic is not guilty because of his illness, then how can a court have jurisdiction to compel treatment? Treatment, says Hutt, is the problem of public-health agencies and not that of the court. He further questions the effectiveness of court treatment programs and contends that their existence merely helps public-health agencies evade their responsibilities.

Hutt's doubts are backed up by a recent study made by Keith S. Dittman, M.D., of the University of California at Los Angeles Health Center. This was a study of the San Diego Municipal Court's alcoholic treatment program. A group of skid-row alcoholics with an average of eighteen prior arrests were required by the court to attend Alcoholics Anonymous and work with a rehabilitation clinic, and were provided with

Judge Truax is a municipal court judge in Vancouver, Wash. This article is reprinted, with permission, from *The Municipal Court Review*, Vol. VII, No. 3, December, 1967.

limited medical attention. This group was compared with a similar group of which no requirements were made. The study revealed that those under court supervision showed no appreciable improvement over those that were not on the program.*

The chronic alcoholic

What, then, should the role of the courts be in working with alcoholics? First, let us be realistic and face some facts. One is that a chronic alcoholic has usually reached the point in his illness where the treatment presently available offers very little hope for improvement. Many court programs when applied to the chronic alcoholic are in actuality a continuance of the "revolving door" in another way. The truth is that the alcoholic who has been arrested ten or more times is the victim of far more than the disease of alcoholism. For him alcohol has taken over his life and destroyed his will to resist. Another fact is that alcoholism is a progressive disease. As the chronic alcoholic's drinking continues, his psychological and physical breakdown decreases his chance for recovery. By the time he has been arrested eighteen times for drunkenness, like Dr. Dittman's experimental group, hope for recovery is small.

If we accept the facts that a chronic alcoholic has little chance for recovery and that the longer an alcoholic continues to drink, the less his chance for recovery, then we should ask, Does a court have any role at all where alcoholism is concerned? When the court tries to treat the potential alcoholic in his early stages and endeavours to stop him from continuing his drinking, a much higher rate of success results.

* Dittman, K. S., and Crawford, G. C., The Use of Court Probation in the Management of the Alcohol Addict. *Amer. J. Psychiat.* 122: 757-762, 1966. But a study by Gallant and others in Louisiana reported remarkable success in a compulsory program: Gallant, D. M., *et al.*, Enforced Clinic Treatment of Paroled Criminal Alcoholics, *Quart. J. Stud. Alc.*, Vol. 29, No. 1, 1968. Both were controlled studies.—Ed.

Court programs directed towards the chronic alcoholic are in conflict with logical reasoning. A doctor would not think of withholding treatment for his cancer patients until their disease progressed to the chronic stage. He places emphasis upon early discovery with immediate treatment. Any progressive disease such as alcoholism requires early identification and treatment. Recovery is in ratio to how long the disease has progressed before treatment starts. Yet many of our courts select for court appearances the destitute and chronic alcoholic in the later stages of his disease and bypass the beginning alcoholic. Court rules that allow bail forfeitures for those arrested for drunkenness do this. As the treatable person still has the economic ability to put up bail, he thus avoids the court; while the chronic has usually degenerated to the point that he can't raise the bail and, therefore, must appear before the judge. By following such a practice the judge finds himself working with those whom he is unable to help and missing the opportunity of involving the early alcoholic who can benefit from a court treatment program.

What the decisions mean

The decisions in the *Driver* and *Easter* cases related only to chronic alcoholics. *Driver* had over two hundred prior arrests and *Easter* had seventy. The opinions repeatedly refer to the chronic conditions of these men. Their conditions met with every definition of alcoholism. The impossibility of recovery of these two was obvious. These decisions do not bar a court from treating the beginning or potential alcoholic; they only bar jailing the person who has progressed to the point of chronic alcoholism from which there is little hope of recovery.

Part of early treatment is overcoming the person's resistance and bringing him to accept his problem while he is still capable of mobilizing sufficient energies to win the fight for sobriety. I would suggest that the courts' role in light of the

rule laid down in these recent cases is to place its emphasis upon the beginning rather than the chronic alcoholic. To do this requires policies requiring court appearances of all persons arrested on any alcohol violation. When they appear, the judge should make appraisal of what, if anything, can be done to help them. If in his opinion they can benefit from a court treatment program, then those that can should be placed under it.

Treatment programs

In this stage many alcoholics will be helped by well-structured probation that prohibits further use of alcohol, makes them face and understand their problem by forcing them to attend Alcoholics Anonymous meetings, introduces them to the fellowship and spiritual powers of AA, and continues for an extended time to keep them under the surveillance of the court. Others may be helped by attending court-sponsored honour classes, by participating in group therapy or by attending lectures and classes on alcoholism.

The recent decisions are not orders for courts to stop helping alcoholics. Instead, courts are directed towards those whom they are able to help; and the frustrations and waste of time and effort that are expended in trying to help the chronic alcoholic are avoided.

(Opposé:)

(Pour illustrer l'interaction de la recherche de base à l'action pratique dans le traitement de l'alcoolisme, l'auteur, directeur du département de recherches de cette Fondation, discute du travail fait par la Fondation dans le domaine biologique durant les huit dernières années. Il montre comment des expériences faites sur des morceaux de peau de grenouille, et l'invention d'une nouvelle sorte de moulin de discipline pour faire marcher des rats intoxiqués, ont apporté d'importants développements dans les recherches sur l'alcoolisme chez les humains.)

The Relevance of Basic Research

By Robert E. Popham, M.A.

This Foundation has financed a program of research on biological factors in alcohol addiction for the past eight years. The work in this area illustrates very well why certain projects come to be regarded as purely academic, and why the feeling develops that the research effort is being wasted. These attitudes are especially likely to arise when the initial question is very complex, as in the present case. It is nearly always necessary to obtain answers to a variety of simpler questions first. Moreover, existing techniques may prove inadequate, and digressions are required to develop new ones. If these smaller steps are not seen in relation to the original question, as often happens, they may well appear to have little or no practical relevance to human problems.

One of the early questions our researchers asked was relatively narrow and specific: it concerned the effects of alcohol on certain events associated with the excitability of living cells. For materials, bits of rat brain and kidney were used; experiments were conducted on an electric eel, and a particularly critical experiment was done on a piece of frog-skin.

These studies, taken out of context, have all the earmarks of exotica—of the purely academic. To those faced daily with the task of helping the alcoholic patient, it must be difficult to see value in a study of frog-skin. In fact, because the same results were obtained for a variety of tissues from different species of animal, it was possible to conclude with some confidence that the effects observed are fundamental—applicable to all animal cells, including those of man. This in turn meant that one probable cellular basis could be pos-

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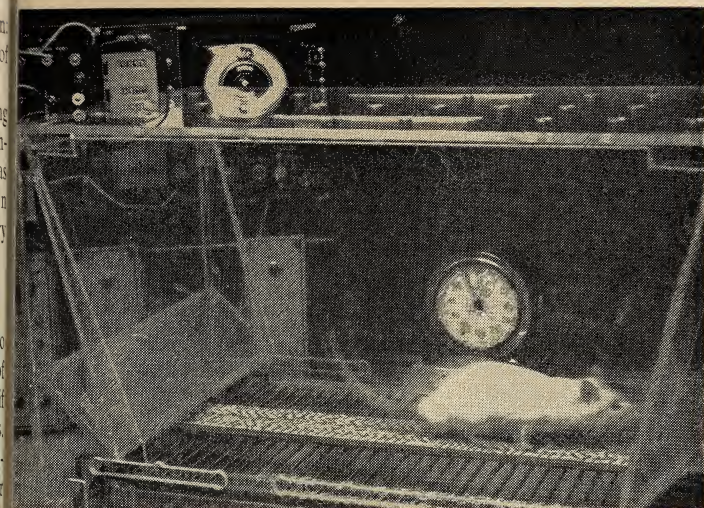
tulated for three of the principal criteria of alcohol addiction: increased tolerance, the withdrawal syndrome, and loss of control.

Important though this may be, an even more exciting outcome was the demonstration that the cellular change involved was transitory: the chronic effect of alcohol was entirely reversible. It follows that the symptoms of human alcohol addiction also may be transitory—a view contrary to the traditional picture of the condition.

Experiments with rats

To begin to test these hypotheses, it was necessary to move from the realm of isolated cells to the behaviour of whole animals. It would certainly have been impractical, if not unethical, to attempt the next step with human subjects. Therefore, a series of experiments was begun on the laboratory rat. But to study the effects of alcohol on the behaviour of the rat, it is necessary to have some means to measure intoxication in this animal. Existing methods did not discriminate blood alcohol levels in the range of interest with sufficient accuracy. Considerable time and money was spent on the problem, and eventually an ingenious device was invented for the purpose. Again, seen apart from the original question, it would be easy to condemn such work as a misdirection of research resources: why study drunken rats when there are so many problems with drunken humans?

The answer is that these experiments are of the utmost importance to our understanding of human alcohol addiction. To date, the work with the rat has confirmed in all respects the hypotheses that had been formed on the basis of the cellular studies. When doses of alcohol were administered to rats in amounts, and over a period, meaningful in terms of a human alcoholic bender, a marked increase in tolerance was rapidly acquired. Furthermore, when alcohol was withdrawn from "tolerant" rats, they showed a distinct hyperexcitability. This had also been seen in isolated tissues after



—ARF Photo

"An ingenious device was invented for the purpose."

A rat walks the moving belt of this apparatus, designed as part of the Foundation's biological research program. If the rat wanders off the belt onto the grid, he activates a timing device and receives a mild electric shock, which chases him back onto the belt. The total amount of time he spends off the belt during the session is related to his blood alcohol level. The inventors of this device describe it as the most sensitive technique that has yet been developed for measuring moderate degrees of alcohol intoxication in small animals.

withdrawal of alcohol; it suggests the marked hypersensitivity that characterizes the abstinence syndrome in human alcoholics.

Again, however, the most exciting result was that no indication whatever was found of any residual tolerance after withdrawal of alcohol. The increased tolerance to alcohol was rapidly acquired, and as rapidly lost. Within two weeks of withdrawal, the rats exhibited no greater tol-

erance for alcohol than animals that had never received any.

What are the general implications of this work to date? I believe there are three:

Craving still unexplained

To begin with, for the first time in the history of alcoholism research—at least with respect to etiological questions—we are acquiring some clarity about the potential role of the different disciplines involved. The symptoms of addiction that now are being explained on a biological basis arise only after a rather heavy consumption has taken place. Neither the Foundation studies nor biological work elsewhere has helped to explain the initial craving for alcohol. We may soon have explained why the alcoholic continues to drink when he is on a bender, but not why he started the bender in the first place. The problem of craving may well prove to be one for the behavioural scientist to solve.

Traditional view threatened

Secondly, if the work described is eventually shown to hold true for humans, the effect on our traditional picture of the natural history of alcoholism will be considerable. Here one is thinking of the progression established by Jellinek in 1946 in his article, "Phases in the Drinking History of Alcoholism." For him and for most workers since, increased tolerance, loss of control and acute withdrawal states were more-or-less distinct events occurring at different times in the life history of the alcoholic. The Foundation work suggests rather that these phenomena are functions of the same underlying biochemical events, and are associated with particular drinking episodes rather than with the life history.

Finally, this line of experimentation holds out the distinct possibility of a rational chemo-therapy for alcoholics. That is, we might expect new drugs to be developed out of a

knowledge of the biological basis of the symptoms that we wish to abolish, rather than being discovered largely by chance as in the case of Antabuse and Temposil.

The latter possibility alone renders the work relevant enough to satisfy the most critical. And if it should come about, it will be partly due to an experiment on a tiny piece of frog-skin.

On the Psychotherapy Of Alcoholism

By Andrew I. Malcolm, M.D., C.R.C.P.

When someone presumes to add yet another paper to the very large collection of papers on the psychotherapy of alcoholism, that person deserves much criticism, of course; but he deserves some sympathy as well, because he must be a very courageous man.

The difficulty is that much has been written, and re-written, and rewritten again. A review of the literature is a painful exposure to the worst excesses of social-scientific cannibalism. Whole bibliographies are lifted from previously stolen bibliographies. Whole quotations from Freud and Jellinek and Menninger are transferred from article to article. And thus does the psychotherapy of alcoholism advance.

In the meantime, many developments in other areas relating to the treatment of alcoholism have been described.

Dr. Malcolm is a psychiatrist in the Central Toronto Clinic of this Foundation. He presented this paper to the second annual conference of the Canadian Foundation on Alcoholism at Quebec City in May, 1967. Professionals working in this field may obtain text of the entire proceedings of the conference, in English and French, by writing to: Albert Forcier, Secretary Treasurer, Canadian Foundation on Alcoholism, Edifice Ste-Foy, 969 Route de l'Eglise, Québec 10^e, P.Q.

We have had the protective drugs, Antabuse and Temposil. We have had conditioned-reflex therapy, aversion therapy, and LSD therapy. Alcoholics Anonymous and a great variety of milieu and group therapies have become established. Day care centres, detoxication centres and halfway houses have made vital contributions to treatment programs. Research into the physiology, sociology and psychology of alcoholism has markedly increased our knowledge of this problem. But there has been no breakthrough in psychotherapy itself comparable, for example, to the discovery of the phenothiazine tranquillizers.

Psychodynamics of alcoholism

For this reason, I propose to touch on the psychodynamics of alcoholism and the techniques of psychotherapy; but I will particularly consider the vital question: who should be considered qualified to work in this field? This will involve some reference to the peculiar nature of the addictions, and whether or not such conditions are as certainly medical as we now seem to hope they are.

It has been said that the ideal teaching situation is one in which the teacher sits at one end of a log and the student sits at the other. The student is somehow influenced by the teacher, and gradually approaches him in learning and sophistication. Psychotherapy has always been something like this. It has been more of an art than a science, and indeed it has been remarkably resistant to the many threatening gestures of the scientists. But among artists the psychotherapists have been admirably thick-skinned, because they have had to endure quite often the ultimate charge: that they do no good.

We are all familiar with the exhaustive studies that have conclusively shown that, if the waiting period is long enough, exactly one-third of the subjects will recover, a third will be unchanged and a third will be worse. It is just a little unsettling to discover that our own hard work is rewarded

with similar results. However, we have a number of comforting defences against despair. We know, for example, that the quality of well-being that we can effect is never, absolutely never, measurable by the detached and steel-hearted scientists.

This is an excellent rationalization when one is dealing with the psychoneuroses. Unfortunately, in the area of alcoholism there is one ultimate criterion that is often rudely used as a measure of success or failure: has the patient stopped drinking? Very often in such cases about all we can say, rather weakly, is that, well, he still drinks, but he is otherwise more secure, more self-confident, and decidedly less depressed. Also he is not drinking as much as he was before, and his wife is much improved. Of course she is going to Alanon six nights a week.

However, I am pleased to say that in spite of such awkward moments psychotherapy continues to be our most necessary instrument. Perhaps this is so because it is the approach to the alcoholic that is most clearly informed by our knowledge of the conflicts in his mind. And by now our knowledge of the psychodynamics of alcoholism is considerable.

The literature

Around the turn of the century, Freud detected in the alcoholic certain fixations referable to the oral period of psychosexual development. The alcoholic's thinking is pre-logical and pre-genital, and this is due to certain traumatic experiences that happened during his earliest years.¹ The mother, according to this view, was alternately indulgent and frustrating; but over all, the patient was deprived of a warm and loving relationship with a mothering person. I prefer to use Sullivan's term here, because it seems clear by now that the essential mothering person does not have to be the biological mother.² That there must be a dependable and loving person in attendance on the infant has been well

established by Bowlby and Spitz.³ Disruption and rejection—and over-protection, which is rejection turned inside-out—will undoubtedly have a hurtful effect on the child.

Alcoholism and schizophrenia

It is remarkable how often the schizophrenic presents this same kind of mother-child relationship. Perhaps Chafetz is right when he suggests that the choice of symptoms in these two primitive illnesses is environmentally and culturally determined.⁴ He suggests that in the case of the alcoholic there is very frequently a significant family figure who depended on alcohol and who became a model for the patient. Indeed, the similarities between schizophrenia and alcoholism are many and are of the greatest interest. In both illnesses there is a very high incidence of deprivation of meaningful emotional relationships in the earliest years. This could be due to the death or absence, either emotionally or physically, of some crucially important figure during this period. Frequently one or both of the parents are alcoholic or mentally ill, or the children are unwanted and sometimes abandoned.

It is certainly true that the alcoholic is a man who repeatedly seeks satisfaction through the use of a magic fluid that promises oblivion and peace. Moreover, he is a depressed man and the alcohol offers a kind of euphoria and thus, again, release.⁵ According to Menninger, the self-destructive drives of the alcoholic are a kind of "chronic suicide."⁶ Others have held that alcoholism is a flight from homosexual impulses.⁷

There seems to be no doubt that certain traits do indeed appear to a significant degree in a general profile taken from a group of alcoholics.⁸ They are depressed. They do show many of the characteristics of the schizoid personality, despite the popular stereotype of the outgoing heavy drinker. They do show a high incidence of psychosexual immaturity. They are hostile, and capable of aggressive acting-out. They suffer from massive feelings of inadequacy, and they

re unduly suspicious of the motives of other people. They are isolated, unsatisfied, guilt-ridden people, who suffer from tension, depression, and much suppressed rage. They are difficult, unreliable people; they are self-centred; and their need for support and love seems insatiable.

It may be that the alcoholic cannot be satiated because, in his case, the instinctual wishes are gratified through the destruction of the love-object. In mature love, the wish is gratified but the object is preserved: there is, then, true satisfaction. However, with the alcoholic there is a constantly repeated demand for love combined with a deeply held belief that his desires will be frustrated. This pattern, which may well have its origins in the patient's earliest years, recurs throughout his life and is reinforced whenever there is another disappointment, another failure.

Repeated regression

The patient, therefore, is constantly driven, through the persistence of this unconscious craving, to seek love and acceptance. He assuages the pain of each new rejection through the use of his briefly satisfying fluid. Every bout of drinking is a regression to a period of his life when he was helpless and might hope to be loved. We may correctly use the word "addiction" to describe this pattern, because the regression is at least temporarily satisfying; this the patient highly overlearns. Thus, when he recovers from his bout, he is crushed with remorse, but he still remembers the relief. He returns to his bottle for another experience of infantile omnipotence and, sooner or later, he is dependent and without control. He has become a problem.

Now there may be something wrong with our approach to this man. On the one hand, the large alcohol-accepting society merely finds him a nuisance and advises him to be less weak, to exert his will and to become responsible. Finally, if he continues to be an embarrassment to the society, it rejects him. On the other hand, the medical com-

munity in general notices him, concludes that he suffers from a medical disease, discovers that he resists treatment, and then also rejects him. Those of us who find him interesting and worthwhile are very few in number. Alcoholics are unlovely, it is generally felt; but they are very numerous.

Alcohol does everything

The alcoholic has a drive towards oral satisfaction; he is an angry masochist who derives unconscious pleasure from hurting himself; he is anxious and depressed; he is bewildered in the world, and he is impulsive. And he has learned that alcohol from a bottle can pacify him, punish him, elevate his mood, sweep away his anxiety and effectively whip his mother or his mother substitute, within an hour.

He is not an easy patient, then, to work with. The therapist who attempts to help him must be warm and receptive but he must also be very certain to establish guidelines and limits. He must endeavour to keep reality very much more in the picture than he might be inclined to do if he were dealing with one of the psychoneuroses. I cannot agree with Scott, however, who appears to take a very hard and reality oriented position from the beginning of therapy.⁹ He confronts the patient with the statement, "I don't think you are willing to pay the price," and he opposes very forcefully every evidence of the use of denial. If he feels the patient is being insincere in the course of the first interview, he simply tells him so.

Rapport comes first

Now this approach may well work in certain cases particularly if there is not the slightest evidence of actual hostility on the part of the therapist. I would be inclined myself, to avoid any statements or questions that could be interpreted by the patient as being moralistic or punitive particularly in the early sessions. Since the rapport between the patient and the therapist is of the greatest importance,

seems likely that not every defence mechanism used by this master of defence can be or should be exposed until rapport has been established.

Much later on, it is most important for the therapist to take a much stronger stand on many issues affecting the patient's contact with society. In the beginning, however, the therapist, without always being passive by any means, must listen well, and must at least avoid a critical and rejecting attitude. The patient has just come from his wife, friends and employer, much wounded through such experiences. The therapist accordingly should be giving and tolerant, but firm. The patient will find the therapist's willingness not to condemn him most reassuring.

Continuing therapy

As time goes on, the therapist will become progressively less protective, and will encourage the patient to form increasingly realistic goals. This sort of process is, of course, the very essence of supportive psychotherapy. The actual type of therapy—whether the goal is insight or support—will depend on a number of factors relating to the tolerance of the patient for anxiety-provoking exploration. There will also be an indication, in many cases, for tranquillizers or Temposil or any of a great variety of other procedures, and these may be used while the psychotherapy is under way. There is no necessary conflict here. If there are physical problems, these too may be treated concomitantly—although, as a rule, any subject who is physically ill is not a good candidate for psychotherapy.

With full knowledge of the physical complexity of alcoholism, I must emphasize that this condition remains basically a psychiatric illness. It is not a disorder that can comfortably be pressed into a rational nineteenth-century medical model.

For centuries the alcoholic was considered a sinner, a moral degenerate. But in the past sixty years or so he has

been seen primarily as a mentally sick man. It is still felt that he suffers from a disease, but now this condition is becoming progressively more medical in definition. To be sure, the alcoholic will eventually suffer from physical illness if he continues to drink, and these conditions must be dealt with in entirely medical ways. But the fundamental neurosis of alcoholism is today as functional and psychiatric as it ever was.

Two kinds of regime

Thus we have two streams, two ways of thinking about the problem. On the one hand, the alcoholic is untrustworthy, uncooperative and lacking in restraint. He is impulsive, he shows a great poverty of will. He must be organized, ordered and helped in spite of himself. If he is resentful of such authority this is all right because he is in strong hands and we know best what is good and necessary for him. If the therapist is afraid of despairing, he will be severe. And of course some alcoholics do very well in these strict regimes.

The other extreme is the very permissive, open therapeutic milieu in which the decisions are made as often as possible by the patient himself. If the therapist is threatened, he may be excessively agreeable. In any case, this approach is infuriating to the hard-headed medical officers among us. It is very disconcerting not to be able to tell the nurses from the kitchen staff, the gardener from the patient, and especially the doctor from the social worker. However, some alcoholics do very well in such settings.

There seems to be no clear indication that either of these extremes is best. What we do know is that in the authoritarian setting, the staff is secure and happy and the patients are militant and resentful. In the permissive setting, the staff is back-biting, indiscreet and discontented; but the patients are usually quite comfortable. It would seem that the patient can survive either type of regime. In the case of the hard one, he will say in the end that it was tough but

air and that at the time he needed much control. Also, he got a lot out of the didactic lectures. If his experience was soft, he will say that it was humane and stimulating. He learned about self-respect while he was there, and he learned how to give and take like a reasonable man.

There is, however, one very good reason why the open, communication-oriented system will turn out to be the right one eventually. It may be necessary, from a completely practical point of view. There are too many alcoholics and too few doctors. Moreover, doctors do not particularly like alcoholics. Alcoholics miss appointments, they relapse, they are held to be poorly motivated, they are bad patients; and doctors only have time to see patients who have a great desire to become well. It is not clear that an alcoholic who fails to show and also fails to pay his bills really wants to get well.

Specialists wanted

Now this is not intended to be merely a criticism of doctors—not in the least. If I had a pain in the chest I would go to a doctor, and he would be glad to treat me. I would be a willing, cooperative patient, and he would be satisfied. I would not go to a social worker with a pain in my chest. On the other hand, if I recognized that I could not control my drinking, I would want to go to a specialist in addictions—whether he was previously an internist or a clergyman.

The alcoholic is a very sensitive man, who is quick to react to any sign of rejection. He rises to the smallest affront, and carries the hurt away with him. He is a collector of injustices. He has a very low threshold for psychic pain, and he is very ready to gather more evidence of his inadequacy and lack of appeal. He needs time, a great deal of support, and friendliness. He needs indications of appreciation all through the relationship, in spite of his repeated testing, his denial and his rationalizing.

After all, he has within him very deep and persisting

reasons for getting drunk. You, as the therapist, are actually presuming to take away from him his beloved and hated alcohol. That's quite a challenge, and he is entirely ready to meet you in the field. You can't possibly be in a hurry unless, of course, his physical condition has deteriorated to the point where there is a real and present threat to his life. You can't simply instruct him to stop drinking, pat him on the head with one hand and give him a bottle of Temposi with the other. You have to establish a relationship with a man who has consistently refused to establish relationships for most of his life. In other words, you have to be a specialist and you have to have time.

G.P.'s have no time

It is very interesting to me to hear so often that the general practitioner must be organized for the treatment of the alcoholic. General practitioners simply do not have time to treat one of the most resistant, disappointing and disruptive patients in the psychiatric array. Moreover, it is a very basic truth that it is not so much the formal training of the worker as the nature of his personality that counts when it comes to psychotherapy. It follows from this that a great many people other than general practitioners, internists and psychiatrists are going to have to work with alcoholics. Nor is this a sort of necessary second choice. There is no particular reason why a doctor should be more effective than a social worker, except perhaps through the operation of what has been called prestige suggestion.

Two things are fundamentally important in the psychotherapy of alcoholism. The first is that the patient must make a commitment to the treatment of the problem.¹⁰ This involves an admission not only that there is a problem but also that further drinking is not possible. And this has to come from the patient. The second is that it is the relationship that is established between the patient and his therapist that counts. Beyond that, of course, the worker should be

entirely familiar with the field of alcoholism. Perhaps that need not have been said, but it was said simply to emphasize that there is very little in the undergraduate training of a doctor with regard to alcoholism that puts him ahead of the other people in the field. It would seem that no worker in the addictions, whatever his formal training, learns anything about the field until he actually enters it.

The closest analogy that I can think of is to politics. The man who becomes a member of Parliament may well have been a merchant or a lawyer. There seems to be no general belief that only people with degrees in political science will be successful in this area. I hope you will forgive me for this possibly annoying analogy. But it is people, then, with specialized training in the psychology of addiction, that we are talking about here. Such people, if they have the time, the tolerance and a genuine interest in the patients, will be the addiction therapists of the future.

Other therapists needed

In short, I am advocating an approach that is designed to make the most economical use of our human resources. There seems to be a great and increasing need for people to work in the specialized field of the addictions. The population is increasing, and the population of addicted people is probably increasing at an even faster rate. I understand that after heart disease, mental illness, and cancer, alcoholism is the fourth most important illness in the country. Yet the number of doctors per capita is not apparently increasing, and the medical societies have expressed some concern with this situation. Moreover, doctors are not well motivated to work with alcoholic patients. It is also true, incidentally, that general hospitals are notoriously resistant to the admission of alcoholic patients.

We must recognize, then, at some point, that we deal here with a specialty. We have a discipline of our own. We are unusual people because we actually enjoy working with

addicted patients. Like the submarine corps, our morale should accordingly be high. But within our discipline the trend towards the reinforcing of barriers between various kinds of workers must be resisted. We are all post-graduates, as it were, and we all came to the field in a state of nearly virginal innocence. We learned about addiction from association with our fellow workers, from reading the specialized literature, and by actually working with addicted patients. We learned, soon enough, that alcoholism was an illness that defied classification in spite of repeated and heroic attempts to achieve it. Is this patient alpha or gamma? Is this case reactive or addictive? These systems are intriguing, but what we eventually discover is that if we have a hundred alcoholics we require a hundred categories.

A psychiatric disorder

In short, the disorder, until it becomes medical with the passage of time, is a typically psychiatric one and as such it is probably best approached through psychotherapy. And the people best equipped to do this work will have come from many fields: from religion, psychology, nursing, medicine and social work; and they will have learned about the field after their entry into it. It might be desirable to call these people "addictionists," rather than "doctors who specialize in addictions" or "clergymen who specialize in addictions."

The alcoholic drinks because he has, at some point in his life, been introduced to one of the world's most ancient and most effective tranquillizers. In fact, if alcohol had not been known for thousands of years it seems altogether likely that some enterprising chemist in Switzerland would have synthesized it sometime in the last ten years as a treatment for anxiety. The preparation would then be advertised as specific for this condition and, unlike other preparations in common use, free of addictive properties.

At any rate, the alcoholic has discovered that his anxiety,

his depression, his anger and his terrible sense of isolation can be well treated by this drug. This is clearly the pathological as opposed to the social use of alcohol: it is alcohol used to treat psychic discomfort or to express hostility towards either the self or other significant people. If the use of the chemical continues to the point where the man appears to be unable to control its further use, then we may refer to him as an alcoholic.

In Ontario there are estimated to be a hundred thousand alcoholics. There are not that many doctors in Ontario; and how many of these have at least twenty hours of time to spend with a single addict to alcohol? If we continue to insist that alcoholics must be dealt with by medical doctors in duly accredited medical hospitals, then we will not even arrive on the field for the first battle. We must see that ours is a specialty that cannot and should not be forced into a strictly medical model. In fact, the most successful approach to the largest number of alcoholics has been made by people who are militantly uninformed by medical principles. I am referring, of course, to Alcoholics Anonymous.

Therapy in AA

And of course, whether they like it or not, the AA's are practising a variety of group psychotherapy. They present a situation in which the patient, or client or subject or member, makes a commitment. He admits that he needs help, and he asks other people to help him. He talks about his experiences, his conflicts and his aspirations. He is accepted by the others, tolerated, criticized, not pitied. He speaks and he listens, he is supported, and he gains insight. He learns to deal with his hostility and his self-consciousness; his anxiety is reduced. He slips and he is not condemned. He is given time.

Now this is psychotherapy—or, at any rate, it does many of the same things that psychotherapy attempts to do. And all this happens in an atmosphere that is friendly, rela-

tively informal and, above all, honest. There is a spirit of camaraderie, of belonging to an understanding group of people. There is no evidence of the clinical sterility that is so threatening and baffling. It is all very human and therefore frequently irrational. And it quite often works.

Professionals too status-conscious

It does not work for every alcoholic, of course, and therefore I am hardly inclined to advise us to release our rats and hang up our white coats. It is still true, however, that we who work in expensive alcoholic clinics might learn much from what the laymen out in the maze are actually doing. Instead, I detect quite the opposite trend. I think we are becoming too bureaucratic, too class-conscious, and too concerned with our image as scientists. Psychotherapy, as I have said, is frequently not very scientific. It is subjective, and it deals with extraordinary accidents of thinking, feeling and acting. Moreover, it is concerned with illnesses that defy classification. And ultimately it has to do with one person, a troubled patient, who consciously has elected to interact with one other person, a therapist, who he hopes will help him to feel well.

It is the relationship that is meaningful. And this is true whether the patient is a member of an AA group or an individual person lying on a psychiatrist's couch. And if this is true, as I believe it is, then there is no reason whatsoever why a whole new discipline could not be created. People would come to this highly specialized field of psychotherapy from many different backgrounds. They would be duly trained and then their remaining differences would largely be measured in terms of their different degrees of aptitude, intelligence and maturity. When this comes about, as I am sure it must, there will be no question of rank or prestige other than the worker's actual position, gained through merit, in the structure of the organization.

The alcoholic would then be treated by addictionists,

and no one else would be as skilled as they. Alcoholics would be treated in addiction centres, and these places would be based on an altogether new model—one derived from a consideration that addiction to chemicals is a unique and very special disorder. If the universities would like their students to know something about the fourth most important illness in our society, then they would send their students to us. We would certainly be unwilling and ill-advised to deform our model of the illness in order to make it qualify as a bona-fide medical one. Our hospitals should not resemble, in detail, general hospitals. Yet this is indeed the trend at the present time, because we are very desirous of status within the respectable medical and university communities.

And now, quite briefly, one final observation. It has been very interesting to me to watch the reaction of our society to the recent increase in the use of marihuana. Police action has been intense, and the press has become pre-occupied with this issue. In a recent case, a youth was sentenced to seven years in the penitentiary for importing marihuana from New York. On the same day three other youths pointed out that they had been drinking before they beat up a stranger, and they were given, therefore, four days in jail. There is a problem here, and we must not be overly satisfied with our attitudes. And many more people will have to do psychotherapy with problem drinkers than are presently allowed to do so.

Notes

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³ John Bowlby in London and René Spitz in Paris both stressed the

influence of maternal deprivation in the development of depression. See especially Spitz, *The Psychoanalytic Study of the Child*, Vol. 2. New York: International Universities Press, 1946.

⁴ Chafetz, Morris E., Practical and Theoretical Considerations in the Psychotherapy of Alcoholism, *Quart. J. Stud. Alc.* 20, 281-291, 1959.

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⁶ Menninger, K., *Man against Himself*. New York: Harcourt, Brace, 1938.

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⁹ Scott, Edward M., The Technique of Psychotherapy with Alcoholics, *Quart. J. Stud. Alc.* 22, 69-80, 1961.

¹⁰ Starrels, R. J., Alcoholism and the Commitment to Therapy, *Am. J. of Psychotherapy*, Vol. XIV, No. 4, 1960.

(L'auteur, un psychiatre à la clinique de cette Fondation à Toronto discute de la psychodynamique de l'alcoolisme et des techniques de psychothérapie dans ce domaine. Il remarque que l'on ne peut pas s'attendre à ce que les omnipraticiens traitent les alcooliques—il y a trop d'alcooliques et trop peu de médecins. Il suggère que l'alcoolique soit traité par des spécialistes en toxicomanie, qui auront appartenu à plusieurs disciplines. Les alcooliques seraient soignés dans des centres de toxicomanie, pas dans les hôpitaux généraux.)

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ADDICTIONS is published four times a year by the Addiction Research Foundation, an agency of the Province of Ontario.

The contents of each issue are selected on the basis of their potential interest to persons engaged in research, treatment or education in the field of alcoholism and drug addiction.

Articles published in ADDICTIONS do not necessarily reflect the views of the Foundation.

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and for payment of postage in cash.

A.I.T. Addictions

Volume 15, Number 2

Summer, 1968

Perspective on Marihuana

By H. David Archibald, M.S.W.

There are four interrelated approaches to such problems as the use of marihuana: research, education, treatment of the pathological user, and legislation. This Foundation is undertaking some study or work in all these areas.

Neither legislation nor education by themselves constitute effective answers to drug problems. Treatment seems appropriate only in some cases: for example, where physiological dependence is known to exist, or where an underlying emotional disorder is the basis for chronic drug use. Research is clearly indicated, and the Foundation has much under way and more planned. None of these approaches will suffice by itself, but their combined application seems likely to be useful.

The demand for new and better information about marihuana and other substances far outruns the present supply of scientific data. Faced with the need to provide interim answers until more conclusive information can be developed,

Mr. Archibald is Executive Director of this Foundation. This article is adapted and expanded from a section of his review of last year's activities in the Foundation's seventeenth annual report, tabled in the Ontario Legislature earlier this year.

A.R.F. staff members have sought to counsel reasonable caution and to avoid making extreme statements.

With regard to legislation, we currently face a patchwork collection of federal laws that have been developed for each drug as it, in its turn, became a matter for public concern. Some drugs that are thought to be mood-modifiers or hallucinogens are not yet covered by any laws, while simple possession of some others is dealt with more severely by the law than some people think it should be.

Severe penalties undesirable

In the statement on marihuana that appeared in the last issue of *Addictions*, we said that "it is probably undesirable to subject users of marihuana to the severe penalties that are provided in the narcotics control legislation. However, it would also be undesirable to legalize the sale and use of marihuana" unless certain questions can be satisfactorily answered—in particular, "the importance of individual differences in users, the effects of different doses, and the circumstances and duration of chronic heavy use."

Marihuana is one of the drugs covered by the Single Convention on Narcotic Drugs, an international agreement arrived at through the United Nations Economic and Social Council and administered by an international board, the Commission on Narcotic Drugs. Canada has signed this convention, and it is translated into Canadian law as the Narcotic Control Act, which controls a spectrum of drugs from marihuana to heroin. Thus the removal of marihuana from the narcotic control legislation in Canada poses not only an internal problem as far as Canada is concerned, but also an external problem in that Canada has been a firm supporter of the Single Convention.

What other courses are open? In this connection, it is worth noting that before dissolution Parliament had been considering a proposal to control LSD under the Food and Drugs Act, which controls the use of many drugs that are

used in legitimate medical practice, such as amphetamines and barbiturates. The question naturally arises: can the control of marihuana be transferred to this act? But here another problem emerges: marihuana is no longer considered a medically useful drug in this part of the world, and has been removed from most pharmacopoeias. Currently the sole use of marihuana in this country is to induce a state of intoxication.

Other possible choices are to place marihuana and certain other substances under an entirely separate act, or to keep marihuana under the present Narcotic Control Act but to modify that act in some way.

Avoid criminal record

The Chief Justice of the Superior Court of Massachusetts, G. Joseph Tauro, concluded in a recent decision (*Commonwealth v. Leis and Weiss*) that "marihuana is a harmful and dangerous drug" and that because of its "harmful and dangerous nature and effects . . . the statutory prohibition of its possession, sale and, thereby, its use does not constitute a legislative interference with any fundamental right of a citizen." However, Chief Justice Tauro also observed that "the legislation might profitably be reviewed with regard to the penalties provided for possessors [of marihuana] as opposed to pushers or where the evidence indicates a first offense with the improbability of repetition. In such cases, the judge should be given wide discretionary powers so that the imposition of a criminal record may be avoided wherever warranted by the facts."

In fact, many Canadian courts are making a distinction between marihuana and "hard" drugs such as heroin, as is shown by the sentences they award. Statistics developed by the Bureau of Narcotic Control in Ottawa show that in 1967 about 61 per cent of persons convicted of possession of marihuana were given probation or suspended sentence rather than reformatory or penitentiary terms, as compared

to about 17 per cent of persons convicted of possession of heroin.

On the other hand, some courts evidently hold that the severity of the seven-year maximum sentence provided for possession of marihuana in the Narcotic Control Act indicates the seriousness of the offence. The *Ottawa Journal* recently quoted an Ottawa magistrate as saying, in imposing sentence on two young people convicted of possessing marihuana, that the penalties provided were "so severe that one had to assume the legislators considered the unlawful use of narcotics extremely dangerous to a well-ordered society." One may wonder, then, to what extent we should rely on flexibility of sentencing practice to justify postponement of some change in the legislation under which the courts must act.

Alternative plan needed

Yet it is idle to propose "liberalization of the drug laws" without proposing at the same time a practical substitute plan for eliminating or at least minimizing whatever damage results from misuse of any or all of the substances involved. Before such a substitute plan can be proposed for discussion and consideration, it is necessary to know much more than is now known about the desire for, use of and effects of the drugs in question. Only research can establish this.

Meanwhile, educational efforts may reduce the misuse of chemicals, but educational statements must be credible. Today's young people do not believe dogmatic statements—especially when it is so easy to find contradictory statements that are equally dogmatic. The "scare" technique—warning against dire consequences of drug use—is not very persuasive, since many young people are likely to know persons who have used these drugs without apparent adverse effects. Discussion is inevitable; and what is important is to ensure that discussion will be well-informed and will make sense in relation to youthful needs and aspirations. As one re-

searcher has commented, many young people do not use drugs and perhaps never will; but they respect many of the views expressed by, or associated with, the drug users.

Padre to the Pubs

By Rev. Gordon Winch, B.A., B.D.

Ministering in drinking places, as I have been doing for the last four years, has been a voyage of discovery for me. Before I began this work I knew little of the inner workings of a beer parlour or tavern—few boys whose mother has headed the York County WCTU have the chance to see much of this sort of life—so I started out with butterflies the size of pussycats in my stomach. As it has turned out, I have been overwhelmed by the warmth of the appreciation that has come my way.

It still startles me to be recognized. One night a while back I went into a Yonge Street tavern, where a well-known entertainer stopped the band when he saw me. "Here's Padre Winch," he shouted into the microphone—as I looked around for a small mousehole to hide in: "He was in here a couple of weeks ago. At that time my band members were very heavy drinkers. He talked to them for half an

Gordon Winch has been appointed Director of the Toronto Distress Centre, a twenty-four-hour telephone service for persons contemplating suicide or otherwise in distress. For more than four years prior to this appointment he was Director of the United Church Alcohol Information Centre, in which capacity he carried on a one-man outreach program in the bars and beverage rooms of downtown Toronto. This work earned him the nickname, "Padre to the Pubs." This article is adapted from a paper Mr. Winch delivered to a conference of United Church Home Mission workers in Toronto last year.

hour, and now I can truthfully say that they don't drink any more. They don't drink any less, either."

In my exploration I have discovered a number of identifiable groups of people—mostly in the beverage rooms, but to some extent in the bars as well:

—**People with problems.** Not surprisingly, the most common problem is marriage breakdown. Many conversations have opened with "Hey, Padre—what does a guy do when his wife leaves him?"

—**People who are lonely.** The drinking place is an alternative to a furnished room, providing company—other people to talk with.

—**People who live in hotels.** When we think of Toronto hotels, we probably forget all but a few large central ones. Dozens of people live, on a fairly permanent basis, in rooms in the Warwick, the Canada House, the Edison, and the several dozen other smaller hotels. I talked with a man in a hotel beverage room who had lived in the same hotel room continuously for seven years.

—**People who are passing through town.** A large city like Toronto attracts scores of people on their way through—going east or west, north or south—and many of them make contacts, or just spend time, in beer parlours.

—**Sailors.** Toronto is a deep-sea port, and sailors stop here for a few hours, a few days or over the winter. The beer parlour is about the only resource we have available for sailors on shore leave.

—**Indians.** For a variety of reasons, some cultural and some individual, the Indian finds his way to the very worst part of the city and is most at home in its poorest environment: the beer parlour. Here he finds temporary relief from the frustration of trying to cope with big-city life, and at times he becomes a serious problem to himself.

—**Ex-convicts.** One of the sad realizations that has come from many conversations with ex-convicts is how stupidly out-of-date and harmful our jail system is. Far from protect-

ing society by putting people away, we actually create a much more real hazard to the welfare of society by creating and fostering deep feelings of abuse, neglect, and injustice. What we seem to forget in our "lock-'em-up" philosophy is that men re-enter the free world we inhabit, often made worse by their experience in jail and ready to commit more harmful acts. The beer parlour is a good place for ex-convicts to meet friends they made in prison.

—**Homosexuals.** I think the Church might profitably enter into a ministry to the sizeable homosexual community that flourishes in Toronto—much of it centred in drinking places. Toronto is known in homosexual circles as the "gay" capital of Canada.

—**Alcoholics.** I do find some alcoholics in drinking places, although it is not an attractive place for an alcohol addict since he can only drink at a limited pace, is cut off when he gets drunk, and must pay much more per drink than when he buys at the wine or liquor store.

—**Skid Row people.** A few of these men come into drinking places, although many of them find beer much too tame and slow—they prefer wine. I do see Skid Row people in my office almost every day.

—**Suicidal people.** It is a common experience in the pubs to meet a person who expresses very strong suicidal or homicidal feelings. It does often seem to be a relatively temporary feeling, no matter how strongly it is expressed, and it can often be changed by intense dialogue.

These are some of the more easily identifiable groups I have encountered. They seem to have some characteristics in common:

—I find that the people in the pubs have a great concern with religion, and with the Church as they remember it or as it comes through to them in the communications media. I find that they are critical of clergymen who are radically unorthodox in matters of doctrine, but they are greatly in praise of religious outreach—the open-air soap-box forum

that St. Luke's holds in Allan Gardens, for example, or the Friendship Centre at Gerrard and Jarvis. As a whole they are uncritical of the Church, but usually desperately confused about the meaning of spiritual living and Christian theology.

—I sense a deep, wide vacuum about the "why" of living. There seems to be a genuine loss of meaning in vocation and in being a citizen, and a feeling of helplessness in the face of world events.

—It is interesting that materialistic values are fairly low among the people in the pubs. There does not seem to be a very high value put on money or on owning things.

Institutions Rejected

—There is practically no sense of orientation towards the community in its recreational opportunities or its political or organizational challenges. There would seem to be a rejection of institutional structures as such.

—There are many people who seem to be dropouts from the middle class, many who are Anglo-Saxons, and many who come from other parts of Canada. While I do meet some New Canadians, as a whole they are not strongly represented in our drinking places.

Implicit in what I have been saying is that for many people the beer parlour (more than the bar) is a type of community that has some meaning. For many people, it is their only community. For others it is a kind of recreational centre where one drops in to relax, as others might do in their living room or recreation room at home.

The drinking place is basically an unpressured world, which does seem to allow people to be a part of something, to let off steam that might otherwise lead to marriage breakdown, insanity or suicide.

In balance, I must add that there are many negative values—but these have occupied us in the Church for decades and need not be catalogued in this article.

The Problem of Overprescription

By G. H. Ettinger, M.D.

The registrars of the provincial licensing boards for physicians and surgeons are becoming increasingly disturbed by the incidence of unwise prescription of narcotics and controlled drugs—amphetamines and barbiturates—by physicians. In Ontario alone, in the period from 1960 to 1966, twenty-eight physicians lost the privilege of prescribing narcotics or controlled drugs, or both, on the order of the federal Division of Narcotic Control. Of these, fifteen had apparently been prescribing these drugs for their own personal use.

When a physician becomes dependent on drugs or alcohol it is a personal tragedy; but when overprescribing leads to dependence by a patient, it is a professional calamity—whether it occurs through misguided sympathy, insufficient acquaintance with the patient, carelessness, or cupidity.

The Department of National Health and Welfare has reported that the consumption of prescribed amphetamines for 1967 amounted to the equivalent of 54,042,000 individual doses of 10 to 15 milligrams; the consumption of prescribed barbiturates in 1967 amounted to the equivalent of 988,000,000 individual 30-milligram doses. The department is also beginning to become alarmed at the large quantities of tranquillizers—which are not at present controlled under the Food and Drugs Act—that are being consumed.

The Research Division of this Foundation is completing a study of the prescribing in Toronto of amphetamines, barbiturates, antidepressants and tranquillizers. We have examined some four thousand prescriptions in pharmacies and an equal number in the out-patient departments of hospitals—

Dr. Ettinger is Director of Medical Planning and Chairman of the Professional Advisory Board of this Foundation. This article is adapted from an address he delivered to the deans of the medical schools of Ontario earlier this year.

including two mental hospitals. So far, we have found that:

—Young physicians prescribe tranquillizers more than their elders do; for example, the ratio of prescriptions for tranquillizers issued by the graduates of the years 1930 to 1939, compared to those issued by the graduates of 1950 to 1959, is three to four.

—Conversely, older physicians prescribe barbiturates more than their juniors do.

—Internists and paediatricians prescribe barbiturates more than the other specialists do.

—Pharmacies fill a high proportion of prescriptions for barbiturates and amphetamines, while hospital out-patient departments fill only a few prescriptions for amphetamines but an extraordinarily high number for tranquillizers and antidepressants.

May overlook danger

The high proportion of tranquillizers prescribed in out-patient departments suggests two possibilities: younger physicians—training in hospitals as internes and residents—may be overlooking the danger that excessive use of these drugs can cause dependence; alternatively, they may be weighing the dependence-producing properties of tranquillizers against their effectiveness and, on this basis, may still prefer them to the barbiturates.

The heavy sale through legitimate channels of drugs that modify mood and behaviour indicates that Canadians lean heavily on these drugs. In addition, illicit manufacture, importation and sale contribute seriously to consumption. The apparent widespread use of amphetamines and barbiturates by young people in universities is alarming not only in itself, but also because it suggests that medical students may come to believe that these drugs are harmless.

Teachers in university medical faculties must warn their students, not only about the unwisdom of personal use of these drugs—possession of controlled drugs, except through

prescription, may be judged to be for the purpose of trafficking and may lead to imprisonment for up to ten years—but also about the risk of personal dependence and the danger in practice of creating dependence among their patients. The College of Physicians and Surgeons of Ontario stated in its *Report* for January, 1967:

May lose licence

“It is the responsibility of a Faculty of Medicine to instruct its students in the pharmacology and therapeutic uses of these drugs [narcotic and controlled] and to impress upon them their addictive and habit forming properties. The student should be made fully aware of the particular risks to which the physician is exposed by being legally permitted to have these drugs in his possession. He should be repeatedly cautioned that when licensed he should never self-prescribe or self-administer these drugs but should rely on another physician for these services. He should be instructed that the abuse of these drugs is considered to be an offence which could result in the loss of his licence.”

The public is becoming aware of the harmful effects of excessive use of alcohol and tobacco, both of which are available for purchase without special permission. Federal and provincial governments tax the consumer heavily for his fun or folly. But the same governments reserve to Doctors of Medicine the responsibility of placing in the hands of their citizens the narcotic and controlled drugs which, if used wisely, may promote health, but which, issued without discrimination, may induce unhealthy dependence. The medical profession must respect this responsibility if it is to continue to hold the respect of governments and of the community. To teach this responsibility is the duty of the medical school.

Solvent-Sniffing and its Effects

By Andrew I. Malcolm, M.D.

At the present time we do not know how many people in Ontario inhale the vapours of volatile solvents in order to become intoxicated, but most workers in the field of drug addiction sense an increase in the practice: some would call it an epidemic. There has been a great deal of discussion on the subject in the communications media and elsewhere, and from some centres—notably Los Angeles, Salt Lake City and Denver—there is statistical information that does indicate increased use.

Some volatile substances have been used as general anaesthetics for decades. The first was nitrous oxide, which was first made by Joseph Priestley in 1772. Sir Humphrey Davy remade it in 1800; he writes that when he inhaled it, he danced around the laboratory like a madman; it acquired the name “laughing gas.” Today, nitrous oxide is sometimes used to keep whipping cream under pressure in cans. Some people inhale it to achieve the excitement of light anaesthesia.

Ether has been used in this way for more than a hundred years. In the 1840's, ether parties were not uncommon in England and the United States; participants would inhale the vapour and become intoxicated. Ether and chloroform are among the anaesthetics used today as intoxicants.

Isolated cases of gasoline-sniffing have been reported in the medical literature for years. I saw my first gasoline-sniffer in 1954: a thirty-five-year-old man who used to sniff it to the point of unconsciousness. Observers in industrial settings have reported the inhalation of other volatile solvents, such as naphtha and carbon tetrachloride.

However, a new phenomenon has appeared during the

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last half-dozen years: instead of seeing isolated or accidental cases of solvent intoxication, we now see whole social groups whose use of volatile solvents as intoxicants seems to be a structural element in their sub-culture. The other remarkable change is that the users now are mostly children and young people, from eight to seventeen years of age. Because the present users are so young, it is possible that the first of them may have discovered the intoxicating effect of toluene independently, without reference to the adult use of similar chemicals. In any case, there was a faddist character to the use of toluene from the time the practice first became known among young people.

In all the early cases that were seen in the current outbreak, the users relied on model airplane glue to produce the intoxication they desired. It was easy and inexpensive to buy—ostensibly in order to pursue a harmless hobby—and it was often easy to steal. It could be concealed on the person without inconvenience. At that time, the term “glue-sniffing” described the practice adequately; but over the last few years users have become aware that a wide spectrum of solvents can produce intoxication, and to be accurate we must now use the more comprehensive term, “solvent-sniffing.”

Characteristics of solvents

The non-alcoholic liquids whose vapours produce intoxication have a number of characteristics in common, two of which concern us in this discussion. The first is that they tend to have low boiling points, so that they are usually quite volatile at room temperature. The second is that while they do not readily form solutions with water, they do with lipids. Hence these liquids are sometimes referred to as “volatile solvents” and sometimes as “lipid-solvents” or “lipid-soluble solvents;” the last two terms are interchangeable.

Lipids—the word comes from the Greek noun *lipos*,

which means fat—is the term used in chemistry and biology to designate fats and oils and their constituents and related substances. Lipids do not readily dissolve in water; some of the alcohols are reasonably good solvents for some lipids, but the alcohols form solutions much more readily with water and should not really be classed as lipid-solvents. Lipids can be metabolized by the body; indeed, all body cells—including nerve and brain cells—contain lipids, just as they all contain water. Alcohol dissolves readily in the water of body cells; the vapour inhaled from volatile solvents dissolves readily in the lipids.

Mechanism of action

There is a fair body of knowledge now about the way in which alcohol operates in the human system, but there is much less knowledge about the way in which the volatile solvents operate. It has been observed, however, that the more lipid-soluble a solvent is, the more intoxicating its vapours are. For this reason, most researchers believe that the intoxicating power of the volatile solvents has something to do with the effect they have on the structure and function of the lipid components of the cell membranes in body tissues—including those of the nervous system—as a consequence of their lipid-solubility. However, there is no agreement as yet about the exact nature of the action.

In all probability the substance most commonly inhaled for its intoxicating effect is still polystyrene cement, which is manufactured for use in assembling model kits whose parts are made of polystyrene. Typically, it contains a quantity of polystyrene dissolved in some volatile solvent such as toluene. In use, the solvent in the cement dissolves the surfaces that are to be joined; and as it evaporates, the dissolved surfaces and the polystyrene in the cement harden together to form one continuous piece of polystyrene.

The most popular brand of polystyrene cement contains toluene as a solvent; others contain acetone, hexane, cyclo-

hexane and various aliphatic (fatty) acetates. The older-style glues that are used to put balsa-wood models together may contain naphtha of petroleum origin, toluene or acetone. In these kinds of glue the solvents do not, of course, dissolve the balsa wood; they serve to keep the adhesive substance from hardening before it can be used. Various other household cements contain toluene, acetone, isopropanol, methyl ethyl ketone and methyl isobutyl ketone.

With the extraordinary spread of publicity about the intoxicating properties of the volatile solvents, a number of other chemical preparations have been added to the list. It is important to note the common availability of these products when we consider the suggestion that airplane glue be banned or restricted, or that noxious odours be added to it to discourage its use. Thus we have nail-polish removers, which contain acetone, benzene, alcohol, and various aliphatic acetates. Even if we were willing to offend the juvenile hobbyist by making his indispensable cement obnoxious, we would approach the denaturing of nail-polish remover with some trepidation.

Then there are the lacquer-thinners. These useful and easily-obtained products contain toluene, aliphatic acetates and various alcohols—methyl, ethyl, or propyl. Various lighter fluids and cleaning fluids contain petroleum naphtha, perchlorethylene, trichlorethane and carbon tetrachloride. Gasoline, the agent most often mentioned in the literature before solvent-sniffing became a social problem, contains naphtha and benzene.

Method of use

The user inhales the vapours from these solvents in as concentrated a form as possible. The glue-sniffer, for instance, squeezes the contents of a tube of glue into a bag, either paper or plastic. He holds the bag in such a way as to prevent the vapours from escaping. He inhales the vapours deeply, until he achieves the degree of intoxication he desires.

Similar methods are adopted, as far as possible, with other solvents.

Within a few minutes the user feels euphoric, confused and dizzy; his speech is slurred. The excitement, delusions and hallucinations in the early stages of solvent intoxication are similar to those frequently described by people in the early stages of general anaesthesia, and the subsequent effects are also similar: as the concentration increases, the narcotic effects prevail; drowsiness supervenes, and unconsciousness may follow. This effect may be the real cause of the deaths that have been attributed to glue-sniffing in the literature: the user who loses consciousness while his face is closely applied to a plastic bag may fall into the mass of hardening cement and be asphyxiated by enclosure in both the bag and the cement.

The ideal anaesthetic for clinical purposes has a short induction period and a very long period of narcosis before death supervenes. In this respect, ether is said to be a good anaesthetic and alcohol a relatively poor one. It seems likely that the volatile solvents are poor anaesthetics in this sense; but as a rule, the user who loses consciousness is immediately exposed to air and thus is allowed to recover quickly.

Acute intoxication

The character of the intoxication will depend on the intensity of the exposure, the personality of the user, the setting, and probably the type of solvent used. In general, the user experiences dizziness, a sense of well-being and a drunken feeling.¹ There have been reports of feelings of great strength, and of various kinds of behaviour that have been described as impulsive, bizarre, aggressive, or dangerous. The immature mental organization of the juvenile is particularly vulnerable to acute derangement, and values that have been only partly learned may easily be rejected. When a user comes from a home or a sub-culture in which values are poorly formed—or actually negative, in terms of those

subscribed to by the larger society—the possibility of anti-social behaviour in a group of solvent-sniffers can easily be appreciated.

There are distortions of perception, visual and auditory hallucinations, delusional ideas and marked changes in mood; these effects may last for fifteen minutes to several hours. Occasionally the sniffer will remain with his supply and inhale from time to time whenever he feels he needs another lift; some sniffers have been known to stay intoxicated for many hours in this way. In any case, whatever the conclusions may finally be about the question of organic damage, there is no disagreement about the hazards of acute intoxication.

What kind of dependence?

Tolerance regularly develops.² The user who achieves the desired high on one tube in the beginning will require several tubes after three months of weekly use. Craving and habituation have been extensively described,³ but physiological addiction and abstinence symptoms remain questionable at the present time. Some users show restlessness, anxiety and irritability following withdrawal, but these symptoms appear to be psychological in origin.

As pointed out above, solvents behave essentially like general anaesthetics; and, like the general anaesthetics, they can cause death through respiratory depression. However, there is considerable disagreement about their ability to cause dysfunction of organs other than the nervous system. The reason for this is probably that there has been no consistency in reporting whether the user was tested in the act of sniffing, a few hours following exposure, or weeks or months later. Another variable, undoubtedly of great significance, is the intensity and duration of exposure to the solvent. This is an area that clearly requires much further study. Though it is established that carbon tetrachloride is a dangerous solvent, it is by no means clear as yet to what

extent the solvents in popular use are physically dangerous.

In some studies, sniffers of model cement have been found to have anaemia and other abnormalities of the blood,⁴ but other studies have not confirmed these findings.⁵ Press and Done report that "in some studies but not in others, sniffers of toluene have been found to have an abnormal incidence of vague neurological signs, hepatomegaly, eosinophilia, and, rarely, acute intracranial hypertension." (Hepatomegaly is enlargement of the liver, and eosinophilia is a condition in which certain normal white blood cells known as eosinophils occur in abnormally large proportions in the blood.) On the other hand, liver function tests have been normal in nearly all reported studies, and there is still no evidence of permanent electroencephalographic abnormalities.

More research needed

"The most consistent findings," Press and Done observe, "have been urinary abnormalities which appear to be transient; their ultimate significance, if any, is unknown at this point." The most frequently reported urinary finding has been microscopic pyuria: pus cells in the urine, but in such small quantities that they can only be detected under a high-powered microscope. Haematuria and proteinuria—red blood cells and proteins in the urine—have also been reported. These symptoms generally suggest a reaction either to some infection or to some injury to the system. Press and Done comment that these urinary symptoms "appear not to be inconsistent in any one individual, despite the continued sniffing of glue in most instances," and they conclude that the symptoms are "transient abnormalities which follow closely on intensive exposure." This may well turn out to be the case; but much more work remains to be done before either a positive or a negative verdict can be pronounced on the question of permanent organic damage due to solvent inhalation.

No one knows the prevalence or the incidence of solvent-sniffing. Most of the sniffers who have been described so far were identified as such after they came to the attention of juvenile authorities—and thus of researchers—following anti-social activity that was related in most cases to their intoxication. They generally had sniffing habits of some duration and records of previous delinquency. Some workers have suggested that there is widespread solvent-sniffing among otherwise normal school-children, and that a great many children try the experience once or twice and do not continue the practice.

But these suggestions have not yet been substantiated; there is virtually no information about solvent-sniffing among otherwise well-adjusted young people. We do not know whether it is even possible for a normal, secure and productive child to become habituated to solvent intoxication. The young people we know of who are vulnerable to habituation have a lot of boredom, anxiety and hostility in their lives; one can conjecture that solvent-sniffing, with its euphoria and perceptual distortions, offers them a temporary escape from these troublesome feelings. A secure child might not need or even enjoy this kind of escape; he might try it once or twice as an experience, but he might not find it an experience that he would want to repeat. It may well be that the young person who continues sniffing, and who eventually comes to the attention of the juvenile authorities as a consequence, is decidedly more unstable or sociopathic than the occasional user.

Subjects are under-achievers

In the studies reported up to the present time, there has been a great preponderance of boys over girls: the ratio is about ten to one. Scholastic performance has been consistently reported as poor; the subjects are under-achievers, and truancy is common even before the onset of sniffing. There is no consensus about socio-economic circumstances:

in the report by Sokol and Robinson, almost all the sniffers were from large families at low socio-economic levels, but in the report by Press and Done the socio-economic circumstances of the sniffers' families corresponded in range and distribution to those of the general population.

Spoiling their chances

There is something peculiarly age-specific about the use of solvents. Though the pattern has been studied now for well over six years, the subjects consistently show a mean age of about fourteen, in a range from eight to seventeen. The question arises, then, what happens to the sniffers after they outgrow solvent-sniffing. As yet there is not enough information to either confirm or deny the suggestion that the sniffer will "graduate" to the use of narcotic drugs or engage in other adult criminal activity. Certainly the habitual sniffer is spoiling his chances in life to some extent by being out of contact for extended periods of time during a part of his life when maturation is proceeding rapidly in people of his age-group. He is already behind, and it may be supposed that sniffing results only in further delay in his progress. This in turn would tend to confirm his sense of futility and lead to the repeated use of the magic solvent that resolves his anger and anxiety.

Later, when solvents are no longer regarded as acceptable chemicals for him to use, it seems likely that he will turn his attention to the rest of the array of chemicals that are commonly available in our society, and select from these his new drug of choice. However, all this is entirely speculative as yet; no transition to narcotic drugs, marihuana, alcohol, methedrine or barbiturates has yet been observed to any appreciable extent; but if a person has experienced drug habituation at ten, it seems only likely that he will be less resistant to habituation at twenty.

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Education on Solvent-Sniffing

By Edward Press and Alan K. Done

(We are fortunate to be able to reprint the following extract from one of the best papers yet written on the subject of solvent-sniffing: the review by Drs. Press and Done that appeared in Pediatrics last year. The question the authors deal with here comes up again and again in this field, in relation not only to solvent-sniffing, but to every means of intoxication that is discovered by a generation of experimenters.

—Ed.)

There is no doubt that awareness on the part of parents, teachers and community leaders is of value in coping with the problem and in bringing to light abuses which otherwise may escape attention and treatment. However, this is difficult to accomplish without a certain amount of publicity which many have feared would be a two-edged sword. There is the threat that publicity regarding any asocial activity may do more harm than good by bringing these activities to the attention of children and youths who would ordinarily never consider engaging in such acts. It is possible, thereby, to spread rather than limit the practice. Thus, many feel that such information should be limited to professional and parent groups only and publicity to the general population should be avoided.

On the other hand, some are of the opinion that, even without publicity in the mass media of communication, knowledge of the various undesirable practices will spread through "underground" channels and that the spread will often transmit misinformation and may omit or minimize potentially serious effects. They believe that the light shed through accurate information and responsible journalism, although it may result in a temporary upsurge of reported incidence, will ultimately prove to be beneficial. Much of the resulting increase, if it occurs, will be a transient, relatively minor one involving youths who are reasonably well adjusted

but are enticed merely to explore briefly a new activity which will quickly be discarded. It is doubtful that such publicity will be responsible for seducing individuals who would not otherwise find their way to some such habituating practice. Aside from alerting peripheral personnel, accurate publicity at least allows the individual to base any decision for or against participating in such activities on all the available facts regarding the possible implications. Whether those who are in possession of such facts have a right to withhold them poses a problem as difficult, it seems to us, as the fear of enticement by advertising. It has been our experience, for example, that while publicity has attracted many experimenters and occasional adherents to solvent sniffing, it has dissuaded approximately equal numbers of individuals from persisting in such activities for fear of the possible consequences.

The authors feel that in those localities where solvent inhalation is a significant problem (not a sporadic, occasional occurrence) judicious publicity is desirable; that this publicity should be accurate, unsensational, and should stress the underlying difficulties and remedial types of activity; that it should not go into graphic details regarding technical aspects of the act, nor should it glamorize the euphoric results. Although any publicity should caution against potential deleterious effects, overexaggeration of toxicity, as has sometimes been noted, is apt to be viewed by juveniles as a "scare" tactic perpetrated by a sworn enemy—the adult. As such, it tends to make all precautions unbelievable.

—Press E., and Done, A. K., Solvent Sniffing. (*Pediatrics*, Vol. 39, Nos. 3, 4, March, April, 1967, pp. 619, 620.)

Sommaires en Français

"Perspective on Marihuana"

Le Directeur Exécutif de cet Institut discute dans cet article certains des problèmes qu'engendrerait l'atténuation éventuelle des peines prévues par la loi relative au contrôle des narcotiques, pour les infractions concernant l'usage du marihuana.

"Padre to the Pubs"

L'auteur, un pasteur de l'Eglise Unie du Canada, a consacré une grande partie de son temps au cours des quatre dernières années, à visiter les bars et les tavernes du quartier central de Toronto dans le but de connaître de près les gens qui fréquentent ces établissements. Ces activités lui ont valu le surnom de "Padre to the Pubs" ou "l'Aumonier des Bistrots." Monsieur Winch décrit ici les caractères, les attitudes et les problèmes de ceux qu'il a connus dans les bistrots au cours de ses visites.

"The Problem of Overprescription"

Le Directeur des Projets Médicaux de cet institut discute dans cet article certains des risques qu'impliquent les ordonnances de narcotiques et de drogues sous contrôle comme par exemple les amphétamines et les barbiturates. Le Docteur Ettinger souligne l'importance qu'il y a à ce que les instituts de médecine rendent les étudiants bien conscients de la dépendance nuisible que crée l'usage improprie de ces drogues sans parler des risques assez sérieux auxquels ils s'exposent tant du point de vue légal que professionnel si la dose prescrite est exagérée, s'ils font la prescription en leur nom ou s'ils en usent personnellement.

"Solvent-Sniffing and its Effects"

L'auteur, un psychiatre faisant partie du personnel de cet institut à Toronto, repasse en revue ce que l'on sait et ce que l'on ne sait pas sur la pratique qui consiste à inhaler les vapeurs de dissolvants chimiques volatils pour l'effet intoxicant qu'ils produisent. Cette intoxication n'est pas uniquement propre à la colle qui sert d'ordinaire à assembler les modèles d'avions; il y a aussi une foule d'autres produits qu'on peut aisément se procurer sur le marché et qui contiennent des dissolvants intoxicants. Il est certain que l'intoxication aiguë causée par un dissolvant chimique peut engendrer chez l'utilisateur des actions antisociales et dangereuses. Il n'est pourtant pas certain que l'inhalation de dissolvants puisse causer des dommages permanents dans l'organisme et on n'a pas encore pu déterminer si les renifleurs de dissolvants s'adonnent par la suite à d'autres drogues.

A.I.T. Addictions

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SCI MED. DIV.

FALL, 1968

Volume 15, Number 3

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ADDICTIONS is published four times a year by the Addiction Research Foundation, an agency of the Province of Ontario.

The contents of each issue are selected on the basis of their potential interest to persons engaged in research, treatment or education in the field of alcoholism and drug addiction.

Articles published in ADDICTIONS do not necessarily reflect the views of the Foundation.

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Editor: Alasdair McCrimmon

PRINTED IN CANADA

Authorized as second class mail by
the Post Office Department, Ottawa,
and for payment of postage in cash.

A.J.T. Addictions

Volume 15, Number 3

Fall, 1968

The Prevalence of Alcoholism And Drug Addiction in Canada

By Wolfgang Schmidt, D.Jur., M.S.W.

A main requirement for an adequate study of the prevalence of alcoholism is a definition that effectively delimits this condition. This is a deceptively simple requirement, for attempts to define alcoholism have long been marked by uncertainty, inconsistency and conflict. I do not intend to go into an extensive critique of current definitions here, except to point out that none of the many in existence today have entirely succeeded in describing clearly what is meant by the term.

To begin with, it might be held that a definition of alcoholism should contain at least two components: the consumption of alcohol, and the damage resulting from it. We might state, then, that "alcoholism is any use of alcoholic beverages that causes any damage to the individual or society or both." But this is a very loose definition, and has little

Dr. Schmidt is Associate Research Director (Social Studies) at the Addiction Research Foundation. This article is based on part of a paper he prepared for discussion at the Foundation's seventh annual summer school at Laurentian University in Sudbury last June.

operational value. Consider two drinkers who have identical drinking patterns, each consuming one litre of wine a day. They distribute their consumption over a twenty-four-hour period in such a way that they are sober at all times. It is clear that this drinking pattern is unlikely to interfere with their normal functioning.

Definition falls down

Now let us assume that one of these two drinkers maintains this drinking pattern until he dies at a ripe age from a cause unrelated to alcohol ingestion, while the other dies of liver cirrhosis that has been caused by his alcohol intake. According to the definition, one of these two drinkers was an alcoholic and the other was not; yet their drinking patterns were identical. The problem here is that the definition rests at least in part on consequences of drinking that are possible but uncertain. Although the consumption of one litre of wine a day increases the *risk* of incurring certain alcohol-related diseases, the concept of risk or probability cannot be part of a definition of alcoholism or, for that matter, of any disease. A definition must not only clarify a concept but also establish its objective reality. The drinking pattern I have described may be thought of as a hazardous habit, but not as alcoholism.

Define by behaviour

To circumvent this difficulty, alcoholism should be described in terms of habitual drinking behaviour rather than in terms of the uncertain consequences of drinking. This has been attempted in the following definition: "Alcoholism is a psychogenic dependence on ethanol or a physiological addiction to it, manifested by the inability of the alcoholic to control consistently either the start of drinking or its termination once started." For the present purposes, we can drop as irrelevant the material referring to dependence and addiction. These terms would require separate definition

and hence should not be part of a definition. Alcoholism, then, is any form of drinking that cannot be consistently controlled.

It is evident that this definition rests largely upon a symptom of alcoholism that is commonly referred to as "loss of control." This simply means that whenever an alcoholic starts to drink it is not certain that he will be able to stop at will. This denotes helpless dependence, which is, according to some investigators, the essence of the "disease alcoholism." The advantage of this definition is that on its basis it is very simple to make a diagnosis of alcoholism. However, its general utility is greatly limited since it does not cover the people we sometimes call "inveterate drinkers," whose drinking consists of regular intake of large amounts of alcohol without conspicuous display of drunkenness. It is quite possible for these drinkers to maintain this pattern without exhibiting loss of control.

The W.H.O. definition

The most widely used definition, and the best so far, is that developed by the World Health Organization. It defines alcoholism as "any form of drinking which in its extent goes beyond the traditional and customary 'dietary' use, or the ordinary compliance with the social drinking customs of the whole community concerned, irrespective of the etiological factors leading to such behaviour and irrespective also of the extent to which such etiological factors are dependent upon heredity, constitution, or acquired physiological and metabolic influences."

The terms in this definition are relative and sociological. Amount of intake is irrelevant, provided that it is above some societal average or norm. But the utility of such a relativistic approach is limited also. The customary dietary use of alcohol, and the drinking customs of different communities, range from total abstinence in a teetotalling community to a very high intake in free-drinking cultures and

subcultures. The chance of finding biological or psychological similarities in drinkers on the basis of this kind of classification seems small.

No definition satisfies

We may conclude, then, that none of the definitions available today describes objectively the drinking behaviour of all alcoholics. The most plausible explanation of this difficulty is the great variability in the manifestations of alcoholism. Each of these definitions describes the drinking of an unknown proportion of an alcoholic population, and it may well be that a single definition covering all alcoholic patterns is impossible. It is probably more useful to think of *alcoholisms* rather than of a single entity, and to define these various manifestations separately.

The problems arising from inadequate definitions are least felt in the clinical field. People who seek treatment in an alcoholism clinic can be identified as alcoholics, regardless of the type of definition one chooses to employ. In these patients, drinking has adversely affected all aspects of their lives. The amounts they have consumed must be considered excessive regardless of the measure of excessiveness one wishes to apply, and they have demonstrated over and over again that they cannot control their intake. In preparing our book *Social Class and the Treatment of Alcoholism*, Reginald Smart, Marcia Moss and I studied thousands of clinical records; we found only two in which the diagnosis of alcoholism was doubtful.

The situation is quite different if one wishes to identify alcoholics in a general population for the purpose of counting them. The task of determining how many alcoholics there are at any place in any given time requires a definition based on a set of behaviours or signs that can be recognized by relatively superficial methods of inquiry. This can be achieved by operational definitions, which are usually tailored to suit a particular epidemiological approach and do not

claim to be universally applicable. In the following, I will discuss the results of such inquiries with special reference to the definitions of alcoholism that were employed.

The prevalence of alcoholism can be estimated directly or indirectly. The indirect methods rest on the assumption that the behaviour of alcoholics *en masse* will be reflected in certain statistics that are regularly reported by governments. These include hospital admissions, convictions for drunkenness and other alcohol-related offences, beverage alcohol sales data, and statistics on causes of death that are wholly or partly attributable to the consumption of alcohol. Although data like these are subject to various errors, they do convey an impression of the magnitude of alcohol problems, including alcoholism. With the help of such information, Jellinek and others have ranked a number of Western countries according to their prevalence of alcoholism. (Table 1, next page.)

Statistics were comparable

The countries in this table have been grouped into a number of categories reflecting the magnitude of the problem in each country. Within each category the countries are arranged alphabetically, since we believe that the data do not warrant discrimination where the differences in prevalence appear to be relatively small. The underlying conceptions of alcoholism in this tabulation rested heavily on damage resulting from excessive intake, and were thus sufficiently similar that comparison among these countries was not vitiated. It is beyond the scope of this article to attempt to explain the variation in prevalence among these countries.

Among the indirect methods of estimating the prevalence of alcoholism, the best known and most often used is the Jellinek Estimation Formula—developed by the late E. M. Jellinek, who is generally agreed to have been one of the foremost workers in the field of alcoholism. Estimates based

TABLE 1
 Ranking of Estimated Prevalence of Alcoholism in a Number of
 Western Countries
 (Countries are listed alphabetically within categories)

Range	Country
Extreme High	France
Upper High	Chile Portugal U.S.A.
Lower High	Australia Sweden Switzerland Union of South Africa Yugoslavia
Upper Middle	Canada Denmark Norway Peru Scotland Uruguay
Lower Middle	Belgium Czechoslovakia England Finland Ireland Italy New Zealand Wales
Upper Low	Brazil Netherlands
Lower Low	Argentina Spain

on the Jellinek formula have been developed for many countries, including Canada.

Jellinek hypothesized that the relationship between the prevalence of alcoholism and the mortality rate from cirrhosis of the liver was sufficiently constant that the former could be estimated from the latter. The proportion of alco-

holic patients who develop cirrhosis of the liver has been fairly closely calculated. This being so, if one knows the number of liver cirrhosis deaths attributed to alcoholism in a given population, it is possible to work back from this figure and estimate the number of clinical alcoholics in the population. "Clinical alcoholics" in this context means persons whose medical and personal characteristics are comparable to those who have been admitted to treatment facilities for alcoholism. The validity of the formula has been criticized, but it is generally agreed that most Jellinek formula estimates that have been published to date are accurate enough for purposes of education and program development.

TABLE 2
Estimated Prevalence of Alcoholism in the Ten Canadian Provinces

Province	Percentage of Population Aged 20 and Older Who are Alcoholics	Number of Alcoholics
British Columbia	2.58	28,150
Ontario	2.50	100,120
Quebec	2.41	76,770
Manitoba	2.20	12,470
Alberta	1.81	14,710
Saskatchewan	1.57	8,530
New Brunswick	1.56	5,120
Nova Scotia	1.45	6,180
Prince Edward Island	1.27	750
Newfoundland	1.11	2,670

Applying the Jellinek formula to the Canadian provinces, then, we get the results shown in Table 2. The general impression gained from this table is the considerable variation in the prevalence of alcoholism among the provinces. Quebec, Ontario and British Columbia have the highest

prevalence, the Maritime provinces rank lowest, and the prairie provinces are in between. The lowest rate is less than one-half of any of the three highest. These considerable differences in prevalence are a particularly interesting aspect of the epidemiology of alcoholism. There is probably no other chronic disorder of similar magnitude whose prevalence varies as widely from jurisdiction to jurisdiction and from decade to decade. It is generally said that the variation over time—and probably also over space—in the prevalence of other psychopathologies is far lower than in the case of alcoholism. This has been particularly emphasized by the incidence of the major psychoses, which some investigators say has not noticeably changed over a number of decades.

Environment is important

The most plausible explanation for the considerable variation in the prevalence of alcoholism is that in this condition environmental factors have a singularly strong effect on prevalence. This observation is supported by the comparisons between nations, leading to the conclusion that national customs, social attitudes and economic factors greatly influence the prevalence of alcohol excess.

Although the estimation methods described so far are appropriate enough for determining the alcoholism rates of major population groups, this technique is less effective if one wishes to study the demographic characteristics of natural (as opposed to clinical) populations of alcoholics. Such information can only be obtained through field study. This leads us to the direct method of estimating the prevalence of alcoholism, which is by actual count of the known alcoholics in a given area.

The most successful prevalence surveys in practice have been those that concentrated on the complete coverage of distinct communities within the national population. This approach—examining complete groups of the population—minimizes the bias that one is likely to get when one selects

only a sample. Surveys of this type are designed to count each case of alcoholism that can be discovered over a given period. The outstanding advantages of this technique are that the diagnostic standards for inclusion can be pre-arranged and that much more collateral evidence on personal characteristics and social background can be collected.

The Frontenac County surveys

During the last fifteen years, two intensive field studies have been made of the alcoholic population of Frontenac County in eastern Ontario. The first was begun in 1951 and the second ten years later. The findings of these surveys have recently been summarized by Robert Gibbins, Associate Research Director (Psychological Studies) of this Foundation, who conducted the first survey and served as consultant to the second. The following is quoted from his summary:

. . . The main objectives of the studies were: (1) to provide a sound basis for estimating the prevalence of alcoholism in the province as a whole; (2) to examine the major demographic characteristics of a natural (as opposed to a clinical) population of alcoholics; and (3) to ascertain what happens to the members of such a population over an extended period of time.

. . . Essentially the same procedures were employed in both studies. . . . These procedures were sufficiently rigorous to ensure that all but the most secretive alcoholics were identified. Detailed information about each case was obtained from documentary sources (e.g., police and hospital records) and from reliable and strategically located informants (e.g., physicians, public-health nurses, social workers, clergymen, employers, and selected city and county officials). For survey purposes, alcoholics were defined as individuals whose histories revealed well-established patterns of undisciplined alcohol use which had culminated in damage to their health in general and/or to their financial and social standing. Cases who satisfied the requirements of this rather loose working definition were further classi-

fied as "problem drinkers," "alcohol addicts," or "chronic alcoholics."

Classification as a *problem drinker* required evidence of excessive drinking of a repetitive nature and, as a consequence of this, an upset in domestic equilibrium to the extent that a family member, friend or associate complained, expressed concern, or sought advice from someone in authority; or a material reduction in work efficiency and dependability to the extent that it had become a matter of concern to an employer or business associate.

Before an individual was classified as an *alcohol addict* there must have been evidence of a seemingly irresistible desire for the effects of alcohol; loss of control of drinking; an apparent inability to break the drinking habit; and deterioration of interpersonal relations as a consequence of the loss of control and inability to stop drinking.

Classification as a *chronic alcoholic* required evidence of a prolonged period of excessive drinking which resulted in the development of one or more of the complicating diseases of alcoholism, e.g., liver cirrhosis, delirium tremens, Korsakoff's psychosis, and so forth.

TABLE 3
Alcoholics per 1,000 Persons Aged 20 and Over in 1951 and 1961

Year	Adult Population	Total Alcoholics	Alcoholics per 1,000 Adults
1951	43,606	698	16.01
1961	53,138	1,245	23.43
Increase in alcoholism rate			7.42
Percentage increase in alcoholism rate			46.37

Table 3 shows that a very substantial increase in the rate of alcoholism occurred in the county during the ten-year period between surveys. In 1951 there were approximately 16 alcoholics per 1,000 adults and in 1961 approximately 23 per 1,000—an increase in rate of slightly more than 46 per cent.

To provide a basis for estimating the number of alcoholics in the province as a whole, the 1961 adult population of the county was stratified according to factors which influence prevalence.

such as age, sex, and rural-urban distribution. Rates of alcoholism were calculated for these strata and projections made from them to the equivalent strata in the provincial population. *The resulting estimate for the province in 1961 was approximately 90,000 alcoholics.* Of these, an estimated 75,100 were males and 14,900 females. It is worth mentioning that the survey estimate corresponds quite well with an independent estimate of 93,450 obtained by means of the Jellinek Formula. . . .

Table 4 shows the distribution of problem drinkers, alcohol addicts, and chronic alcoholics in the county in 1961.

TABLE 4
Classification of the 1961 Alcoholic Population

Category	Per Cent
Problem drinker	39.5
Alcohol addict	43.2
Chronic alcoholic	17.3

As mentioned earlier, a major objective of the two investigations was to ascertain the fate of members of a natural alcoholic population after an extended period of time. Table 5 shows the status in 1961 of the majority of cases detected in 1951.

TABLE 5
Status in 1961 of the 1951 Alcoholics

Status in 1961	Per Cent
Active	36.0
Inactive	22.8
Dead	17.6
Missing	23.6

The group designated "Active" is comprised of those individuals identified as alcoholics in both surveys. The group labelled "Inactive" is made up of individuals who were identified as alcoholics in the first survey but not in the second.

The cases labelled "Missing" were individuals in the 1951

survey who were not residing in the county in 1961, and who did not appear in the provincial death records. It is presumed that the majority of this number had emigrated from the county.

TABLE 6
Causes of Death in the 1951 Alcoholic Population

Cause of Death	Per Cent
Diseases of the circulatory system	41.4
Accidents	14.4
Diseases of the digestive system	11.9
Respiratory diseases	11.8
Vascular lesions	9.4
Malignant neoplasms	8.9
Other	2.2

Table 6 shows the leading causes of death among those who died during the period between the surveys. It is worthy of note that the chief difference between this listing of causes of death and that obtained for the general adult population of Ontario is the higher percentage of deaths due to accidents and gastro-intestinal disease—which includes cirrhosis of the liver—among the Frontenac County alcoholics.

TABLE 7
Classification of the 1951 Alcoholic Population
According to Degree of Alcoholism in 1951 and Status in 1961

Degree of Alcoholism in 1951	Status in 1961				Total (per cent)
	Active (per cent)	Inactive (per cent)	Dead (per cent)	Missing (per cent)	
Problem drinker	30.9	30.9	13.2	25.0	100.0
Alcohol addict	45.3	14.0	16.0	24.7	100.0
Chronic alcoholic	27.3	9.1	54.4	9.1	100.0

Table 7 shows that status at the time of the second survey varied according to presumed degree of involvement with alcohol in 1951. The data in the table indicate quite clearly that the

mortality rate during the years between surveys was considerably higher for the chronic alcoholics than for either the problem drinkers or the alcohol addicts. They also suggest that persons classified as problem drinkers in 1951 were far more likely to be inactive in 1961 than those classified as alcohol addicts or chronic alcoholics.

The group of apparently inactive alcoholics (22.8 per cent—Table 5) is of considerable interest, for several reasons. Since no evidence could be found of their having been admitted to any of the county's hospitals or clinics, or of their having received formal therapeutic assistance from the county's professionals (or AA) for alcoholism or its complications, it is not unreasonable to suggest that *"spontaneous recovery" from alcoholism did occur in 22.8 per cent of all cases during a ten-year period.*

TABLE 8
Classification of Those Listed as Inactive in 1961
According to Degree of Alcoholism in 1951

Category	Per Cent
Problem drinker	74
Alcohol addict	23
Chronic alcoholic	3

As shown in Table 8, the "inactive" group was composed mainly of individuals who had not progressed beyond the "problem drinker" stage. Most of them were in occupations requiring some formal training or degree of skill, and were steadily employed in a closely supervised working environment. It is particularly noteworthy that 23 per cent of the inactive cases were classified as alcohol addicts and 3 per cent as chronic alcoholics in 1951. The fact that they were able to become abstinent, or at least to modify their drinking behaviour to the point of unobtrusiveness, with little or no sustained professional assistance, should dispel some of the unwarranted pessimism about the prognosis of alcoholism.

A further finding of these surveys concerns the social
(Continued on p. 29)

Alcohol Use in Canadian Society

By Jan de Lint, M.A.

Canadian drinking has not been given much attention in the alcohol literature. The most likely explanation for this is that the use of beverage alcohol in Canadian society, unlike its use in Jewish, French, Irish or Italian societies, is not characterized by the predominance of one particular drinking pattern or one particular alcohol problem. There are many different drinking patterns in Canada and many different problems associated with alcohol use.

An examination of the drinking patterns in a society can offer us some useful clues about the magnitude and nature of alcohol problems in that society. Particularly, the problems of intoxication and of physical damage caused by long periods of excessive drinking are closely associated with the prevalence and type of drinking patterns.

To what extent a study of drinking patterns can also provide us with meaningful information about the magnitude and nature of clinical alcoholism is less clear. It has been suggested, for instance, that drinking to relax, to unwind, or to relieve social and physical discomfort, may precede clinical alcoholism. On the other hand, many who at times drink in this manner do not become alcoholics; also, it should be noted that many factors other than alcohol use contribute to the development of clinical alcoholism.

How should drinking behaviour be studied? Some authorities in the alcohol field have gone so far as to try to develop a general theory of drinking. At present, such a theory is as impossible as a general theory of human behaviour. At best it is a frame of reference suggesting the

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type of factors that may be relevant in drinking behaviour. Thus it has been stated, for example, that people drink for five reasons: ritual, leisure, tension-release, to express solidarity or social differentiation, and to facilitate interaction. It has also been suggested that drinking is affected by the accessibility of alcohol and by the rules of society.

The major objection to such statements is that they are too general to have any meaning. There are too many areas of human behaviour that can be similarly defined. For instance, eating can have all these "functions" and is similarly affected by the accessibility of food and the rules of society. But no one has seriously proposed a general theory of eating.

In other words, I suggest that we should not aim at a general theory of drinking; it is not really meaningful. What we want to study instead are those patterns that can be usefully associated with the problems that face us. The questions we should ask should be practical and to the point. I would like to describe in this article the major patterns and trends in Canadian drinking, and I would also like to show their relevancy to the problems associated with alcohol use: to intoxication, to clinical alcoholism and to physical damage as a result of regular, excessive drinking.

Present level of consumption

An obvious point of departure in our sketch of the major aspects of alcohol use in Canada is to consider, first of all, the general level of alcohol consumption. In 1966, the latest year for which statistics are available, the average Canadian adult consumed about 1.79 Imperial gallons of absolute alcohol per year—an amount equivalent to 480 twelve-ounce bottles of beer or 29 twenty-five-ounce bottles of whisky. Compared to other countries, this level of consumption is not high. The average drinker in France, Italy or Switzerland consumes at least twice as much.

Alcohol use in Canada has increased considerably during the last three decades. At present, average consumption is

at least three times that of 1935. This increase is attributable in part to an increase in the proportion of adult users in the general population: at present, about 70 to 80 per cent of Canadian adults use alcoholic beverages. Attitudes towards drinking have changed much in Canada since Prohibition, and very few Canadians still feel that alcohol sales should be abolished.

Changes in drinking patterns

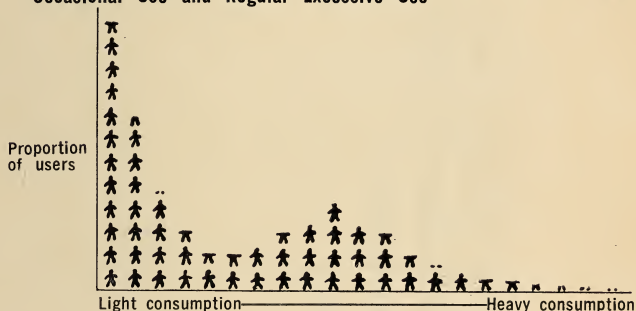
The overall increase in alcohol consumption cannot only be explained with reference to a wider acceptance of drinking in Canadian society. It is also attributable to an increase in the prevalence of certain drinking behaviours. For instance, excessive alcohol drinking (for example, inveterate drinking or clinical alcoholism) usually accounts for a large share of total alcohol consumption. These drinking behaviours are much more prevalent now than in the recent past, and consequently the increased prevalence of these types of drinking behaviour *alone* has contributed more to the overall increase in alcohol consumption than has the increased proportion of users in the adult population.

The overall increase in alcohol consumption has not been brought about by similar increases in the use of beer, wine and distilled spirits. Since these three types of alcoholic beverages differ in cost, alcohol strength, taste and tradition, they are quite differently involved in the many Canadian drinking patterns. It appears that the drinking patterns involving distilled spirits and wine have increased somewhat more rapidly than the patterns involving the use of beer. Beer consumption still accounts for most of the alcohol consumption in Canada, but the trend seems to be in the direction of distilled spirits and wine. At any rate, the sales of these two beverages have increased more rapidly in recent years than the sales of beer. I will come back later to the significance of these current trends in specific alcoholic beverage consumption with reference to alcohol problems.

However, before doing this, I would like to discuss other major aspects of Canadian drinking behaviour.

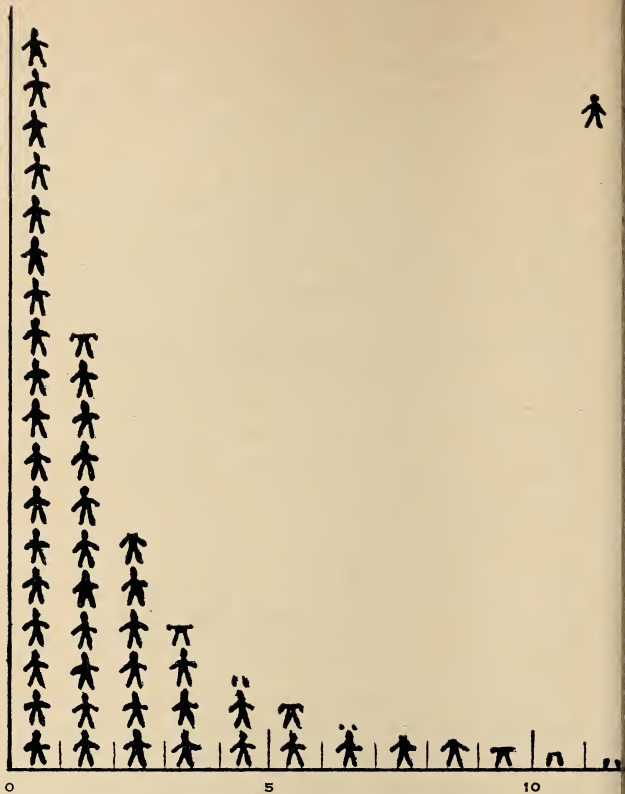
To know that in Canada the average yearly consumption of alcohol per adult is about 1.79 gallons of absolute alcohol has little meaning by itself. The probability of meeting someone who indeed consumes 1.79 Imperial gallons of absolute alcohol yearly—of which 58 per cent is beer, 8 per cent is wine, and 34 per cent is distilled spirits (according to the 1966 statistics)—is obviously very small. In fact, most Canadians do not use all three kinds of alcoholic beverages, and the vast majority drink considerably less than 1.79 Imperial gallons of absolute alcohol per year.

Fig. 1 — Distribution of Consumption if Predominant Patterns are Light Occasional Use and Regular Excessive Use



What is of interest, however, with reference to the type of drinking behaviour present in Canadian society is how alcohol consumption is distributed over the population of adult users. One might expect some clustering of drinkers around certain levels of consumption: a lot of light, occasional drinking on the one side of the distribution curve and many excessive users on the other (Figure 1). This, however, is not the case. The distribution of alcohol use in Canada has been found to be regular and smooth: a gradually decreasing proportion of Canadian adults consume a gradually increasing quantity of alcohol (Figure 2).

Fig. 2—Distribution of A



Average Daily Consumption

84.37%
(8,117,359)
drink
0-5 cl. daily

9.87%
(949,607)
drink
5-10 cl. daily

10-

* A pint of Canadian beer (5% alcohol by volume), or a 1½-ounce centilitres of absolute alcohol.

Consumption in Canada

Drinkers



litres of Absolute Alcohol*

1.24%
(119,302)
drink
15-20 cl. daily

1.56%
(150,090)
drink more than
20 cl. daily

Canadian distilled spirits (40% alcohol by volume), contains about 1.7

It is clear that the vast majority of Canadian drinkers are very moderate consumers. In fact, as Figure 2 shows, 84.37 per cent consume less than five centilitres of absolute alcohol daily. This is slightly less than three pints of beer (5 per cent alcohol by volume) or three drinks containing 1½-ounce shots of distilled spirits (40 per cent alcohol by volume). On the other hand, 1.56 per cent consume more than twenty centilitres daily—in other words, twelve or more pints of beer, or twelve or more 1½-ounce shots of distilled spirits. Although relatively small, this group accounts for nearly 20 per cent of the total alcohol sales in Canada.

Transition is gradual

It is not difficult to appreciate the difference between the 8,117,359 drinkers on the extreme left of the distribution curve who consume between zero and five centilitres of absolute alcohol daily, and the 150,090 drinkers who consume more than twenty centilitres. The latter group is either grossly intoxicated at frequent intervals or in a continuous state of mild intoxication. What is difficult to understand is why the transition from moderate consumption to excessive consumption is so gradual. Only a relatively small proportion of drinkers gravitate towards the extreme range of consumption. On the other hand, many Canadian drinkers are dangerously close to these high levels.

Many are beginners

Examination of the consumption distribution curve indicates that most Canadians have established moderate drinking habits. However, a large proportion of the drinkers at the lower ranges are still beginners—young adults in the process of acquiring a variety of drinking patterns.

One person may enter the population of drinkers at age 20; by age 30 he may have acquired a variety of drinking habits involving a quantity of about four ounces of whisky

daily. At age 40 his habits may involve a somewhat larger quantity, but at that point his drinking behaviour may vary relatively little for a number of years. When he approaches 60 or so, his yearly consumption may fall back somewhat.

Another person's place in the distribution curve may also move up with the years, but at the age of 40 his drinking habits may not become stable. Instead, he may continue to gravitate towards the tail end of the curve.

Many other hypothetical drinking histories could be invented to illustrate the dynamic aspects of the distribution curve. It is true, of course, that at any one time we may say that the population of drinkers consists of so many very moderate, so many moderate, so many medium, or heavy, or excessive drinkers. But we should keep in mind that individual drinkers are moving to different places in the curve all the time.

Where to draw the line?

Whatever the nature of the different drinking careers, the overall result at any one point in time is a fairly smooth distribution of consumers according to the quantities they consume. The distribution does not suggest any point, any quantity, where we seem to be dealing with different *types* of drinkers. The traits that would suggest that four-ounce drinkers are much different from five-ounce drinkers are unknown.

The tail end of the distribution curve is, of course, of particular interest to us. It contains many alcoholics in the clinical sense, but it also contains a considerable number of other drinkers. All of them consume quantities hazardous to health. It would be difficult to pinpoint exactly at what consumption levels drinking becomes hazardous. Some scientists have placed it at nine gallons of absolute alcohol yearly or about ten ounces of whisky daily. Many other factors also have to be considered, such as the age and the nutritional habits of the drinker. Whatever the case, the present distri-

bution of consumption clearly shows that a substantial number of Canadian drinkers consume quantities hazardous to health.

Reasons for drinking

Let us now turn to the different ways in which beverage alcohol is used in Canadian society. For what reasons do Canadians drink? Can we say, for instance, that regular social use is more prevalent than other types of use? To answer these questions we must keep in mind that the prevalence of each type of alcohol use cannot be estimated, since there is a great deal of overlap in reasons for drinking. A bottle of beer on a warm afternoon may be consumed for thirst, relaxation, taste and pleasure all at the same time. Similarly, a martini before a luncheon meeting may serve a variety of "functions": to facilitate interaction, to make the occasion more enjoyable, to increase the appetite. But although we cannot clearly separate alcohol consumption according to different types of use, we do have some information about the relative importance of the various reasons why Canadians drink.

The use of beverage alcohol to celebrate an important event was often mentioned by Canadians who were interviewed in the course of a survey of drinking behaviour. This use is also clearly indicated by the large proportion of total distilled spirits and wines sold around the Christmas season.

Medical use of alcohol

With reference to the importance of medical use of beverage alcohol in Canadian society, we must draw a distinction between institutionalized medicine and traditional or home medicine. The extent to which beverage alcohol is prescribed by physicians in the course of treatment would refer to its role in institutionalized medicine. This use is relatively unimportant. However, traditional or home medical use of beverage alcohol appears very prevalent in Canadian society.

Many people reportedly drink to promote sleep, to relax, to unwind, or to relieve social or physical discomforts. These are essentially medical uses of alcoholic beverages.

Another frequently reported use of beverage alcohol is as part of the daily diet. Alcoholic beverages are essentially foods, and often form part of a meal or are used to quench a thirst. From alcohol sales data we learn that beer sales are up at least 25 to 30 per cent during the summer months and that large quantities of this beverage are consumed, particularly on warm days. A rather high prevalence of dietary use of beverage alcohol is also evident from the type of answer given by many Canadians when asked why they drink alcoholic beverages: they often say that they drink to quench their thirst, or to increase their appetites.

Convivial drinking

Alcohol use in the course of entertaining guests at a party, or as a gesture of hospitality, or just to make a get-together more enjoyable, is also very frequent in Canadian society. It is of some interest that this type of use, as well as the other types that we have discussed, tends to take place more and more in the home rather than in a bar or tavern. This means that an increasing number of Canadians need to keep alcoholic beverages in the home and must learn to exercise control over their drinking. It is difficult enough at times to leave a well-stocked refrigerator alone when one feels like a late-night snack; the same would certainly apply to a well-stocked liquor cabinet or bar. The trend towards home use also implies that other members of the family are confronted with the use of beverage alcohol more directly, and at an earlier age.

I have noted that overall alcohol consumption is increasing in Canada, as is the proportionate use of the stronger alcoholic beverages—the distilled spirits and wines. These changes are the results of a wider acceptance of use and an increased prevalence of various uses of alcohol, particularly regular

social use. It seems that Canada is moving in the direction of those societies where the consumption of beverage alcohol is much more a part of social life.

The affluent consumer

This is made easy by the prosperity currently enjoyed by many Canadians. The affluent person can afford to engage in an increasing variety of consumptive behaviours, and the different uses of beverage alcohol are among the options open to him. Income levels as well as the accessibility of alcohol in terms of cost and outlets are important factors in explaining trends in beverage alcohol use. This does not mean, however, that alcohol consumption will continue to increase as long as income goes up and as long as alcohol beverages become more accessible. Observations of drinking behaviours in other societies have shown this to be the case only where drinking is not very widely accepted and where several drinking behaviours are still not too prevalent.

It can also be predicted that the increase in alcohol consumption will be largely the result of increases in the use of distilled spirits and wines. These types of beverage alcohol are more fashionable and more intimately associated with upper-class and middle-class behaviour. They are also better adapted to satisfy the affluent Canadians' search towards more variety in their consumptive behaviours.

Thus far, I have described the major problems and trends that are characteristic of Canadian drinking and that are relevant to the problems associated with alcohol use. I would like now to examine how these specific changes in the consumption of beverage alcohol in Canadian society do indeed affect our chief alcohol problems: intoxication, alcoholism, and physical damage due to chronic excessive drinking.

First of all, I have noted a continued rise in the general level of alcohol consumption. This in itself is often considered undesirable from a public-health point of view. Many governments have traditionally taxed alcoholic beverages

very heavily and have justified this taxation as a public-health measure aimed at curbing alcohol consumption and alcohol abuse.

Some statistical evidence indeed suggests an association between alcohol consumption and the prevalence of alcohol problems. Consequently it has been argued that high levels of alcohol consumption bring about a high prevalence of alcohol abuse. However, this is a rather naïve interpretation of the statistical evidence. One may with equal justification argue that a high prevalence of clinical alcoholism and habitual excessive use brings about high levels of alcohol consumption. At any rate, to judge the desirability or undesirability of increased alcohol consumption in Canadian society is certainly not a simple matter.

It may be better to rephrase the question as follows: How is a wider acceptance of alcohol use and a higher prevalence of regular social drinking going to affect the incidence of alcohol problems? In addition one may ask what role alcohol taxation can play in increasing or reducing these problems.

Good drinking practices

With reference to intoxication, it can be argued that a higher prevalence of social drinking, particularly at home, tends to facilitate the development and dissemination of good drinking practices and therefore to reduce the incidence of intoxication and related forms of abuse.

It would seem, then, that increased alcohol taxation might not be very desirable as far as the problems of intoxication and related forms of abuse are concerned, since a further rise in the cost of beverage alcohol would tend to reduce the prevalence of social drinking.

In the case of clinical alcoholism, it is doubtful whether increased or decreased social drinking will have very much effect on the magnitude of this problem. It is conceivable, in view of the availability of a great variety of drugs other than alcohol, that the emotional states of the clinical alco-

holic may eventually find forms of expression other than the frequent benders. At any rate, the cost of beverage alcohol is not likely to have much effect on this type of drinking. After all, to drink frequently to excess only requires about \$1,000 a year. This is a relatively small sum of money for a person who has frequently lost all interest in other consumption items such as a car, a home, a TV set. The cost of alcohol would have to be increased very much indeed to affect this type of drinking.

Physical damage

In the case of the third major problem associated with alcohol use—the problem of physical damage due to regular, excessive use over long periods of time—the situation is quite different. This problem will undoubtedly become more serious if the trend towards a wider acceptance of drinking, and particularly towards an increased prevalence of dietary and convivial drinking patterns, continues.

It might perhaps be argued that a program of education aimed at informing Canadian drinkers about the levels of drinking that are known to increase significantly the probability of sustaining some physical damage may help to reduce the prevalence of regular, excessive drinking. However, the continued prevalence of cigarette smoking despite its association with lung cancer shows that public education alone is not very effective. Therefore, to tax beverage alcohol relatively heavily would seem to be well justified in the case of this type of alcohol problem. It makes the hazardous habit of regular, excessive use also very expensive.

Let us now consider the situation in Canada with respect to the consumption of specific alcoholic beverages. I observed earlier that a relatively high proportion of alcohol use is in the form of beer, but that this proportion has somewhat decreased in recent years. What is the significance of this pattern in relation to problems of alcohol use?

In the alcohol literature the question of weaker versus

stronger beverages has been frequently discussed. Many governments have clearly favoured the sale of weaker alcoholic beverages, usually by taxing distilled spirits considerably more heavily than beers and wines. Is this differential treatment of the specific alcoholic beverages really justified? Do distilled spirits, in fact, contribute more to alcohol problems than do beers and wines?

The evidence for this position is not very convincing. It has been shown experimentally that intoxication is much more rapid if a given quantity of alcohol is ingested in the form of distilled spirits than if the same quantity is consumed in the form of beer or wine. It has also been suggested that inebriates do not prefer the weaker beverages. Finally, it has been pointed out that in societies with high consumption of distilled spirits, such as the Scandinavian countries, the prevalence of problems associated with alcohol use is also high.

Examining the arguments

With reference to these arguments, however, it should be noted first of all that distilled spirits in Canada and elsewhere are typically consumed diluted and at strengths not unlike that of wine. Secondly, the argument that in countries where there is much consumption of distilled spirits there are notably more alcohol problems is not meaningful. It so happens that in these countries drinking is not widely accepted and regular social use is not very prevalent. Thus, with equal justification, the incidence of their alcohol problems may be attributed to the marginal acceptance of drinking rather than to the strength of the alcoholic beverage most often used.

Finally, with reference to the statement that alcoholics tend to prefer distilled spirits, I would like to point out that excessive alcohol use in Quebec involves beer rather than the two other types of beverage alcohol, while the Skid Row drinkers in Toronto invariably consume the inexpensive

Canadian wines. It is probably quite true that the typical clinical alcoholic who seeks gross intoxication prefers the stronger beverage—if he can afford it. Whether this is necessarily an argument in favour of the relatively high cost of distilled spirits, I do not know.

Differential taxation?

With reference to other alcohol problems, let us consider what is likely to happen if distilled spirits are taxed out of reach for almost all people. This has indeed occurred in Czechoslovakia, where alcohol is consumed almost exclusively in the form of beer. Nevertheless, the alcohol problems there are apparently no less serious than in societies where other alcoholic beverages are used. Both liver cirrhosis mortality rates and the number of cases of alcoholic dementia—loss of intellectual function due to brain damage—are rapidly increasing. On the other hand, the prevalence of alcoholic psychosis has dropped markedly. It has been suggested by Czechoslovak observers that heavy beer drinkers typically think of themselves as being very healthy individuals and that alcoholic dementia and other signs of physical damage are often present in this group of people while they still consider themselves healthy.

It would appear from all the evidence available in Canada and elsewhere that differential taxation of specific alcoholic beverages is not justified. To label beer “the drink of moderation” and to associate alcoholic problems primarily with the use of distilled spirits is not supported by the facts. Desirable drinking practices are not brought about by the beverage used, but by the people who use it.

(Continued from p. 13)

class distribution of the alcoholics that were identified. It is frequently said that "alcoholism is no respecter of persons." Statements of this sort are often meant to imply that, at least with respect to such broad categories as socio-economic class, the risk rates and prevalence rates are about equal. Investigations concerned with these questions, including the Frontenac County surveys, have challenged the credibility of this contention. From a comparison of the occupations of the alcoholics in the survey it became evident that the higher occupational categories had lower rates of alcoholism than the lower categories. The rates also varied according to education, with the highest rates among those having little formal education. This finding accords well with the results of many other investigations, which also indicate an inverse relationship between occupational status and the prevalence of alcoholism.

The epidemiological method

The data that have been presented so far indicate considerable differences in rates of alcoholism among geographic regions, between males and females, and among various sub-groups of a general population. The mapping of rates in such a manner is generally referred to as the epidemiological method. Its potential value is twofold. Firstly, knowledge of prevalence may give information that is immediately useful in the organization and administration of treatment services. Secondly, and probably more importantly, all the main factors in the etiology and development of a disorder—genetic, physical or social—can be investigated by epidemiological methods. In these investigations, the first step is usually to establish that rate differentials exist. This information is derived from the study of the distribution of the disorder in relation to time, space, or the distinguishing characteristics of the social groups affected. From these distributions, one attempts to uncover clues about factors responsible for the

variation in risk rates. An example may clarify the ensuing process of investigation.

It has been consistently found that rates of alcoholism are much higher in urban than in rural areas. In order to explain this difference, one has to search for components of urbanism that may be responsible for the relationship. Such components may suggest themselves on grounds of widely held beliefs, by intuition, or by analogy to other social problems that also occur with higher frequency in urban areas. In the case of alcoholism, an investigator would select for study certain seemingly significant components of the relationship between the higher rates of alcoholism and the urban milieu. The following might be considered: the easier accessibility of alcohol due to more numerous public drinking places, the probably greater tolerance of drinking in urban life than in the rural areas, and the generally higher socioeconomic level concomitant with city living. The latter may be particularly relevant, since it is known that personal income and per-capita consumption are correlated.

It should be pointed out that evidence derived by these methods is always circumstantial, in that it may be sufficient to suggest a causal relationship but can never give final proof of it. Different methods have to be applied at this stage of an investigation, but it is beyond the scope of this article to go further into these possibilities.

Prevalence of drug abuse

When we turn from our discussion of the prevalence of alcoholism, which has been researched with some thoroughness, to examine the prevalence of the abuse of other drugs, we find that our knowledge is very limited. Generally speaking, we have less scientific information on the epidemiology of drug addiction today than we had on alcoholism twenty years ago. One frequently finds statements in various media to the effect that drug addiction and drug abuse have reached epidemic proportions. This may well be the case,

but there is little hard information to back up these statements.

Despite the control exercised over most psychoactive drugs by the law, they are frequently obtained without prescription by people who use them for reasons other than their intended medical purpose. It is the prevalence of this uncontrolled use that I want to discuss here. The drugs involved fall into four broad categories: the narcotics, the barbiturates, the amphetamines, and the hallucinogens. All these drugs may produce some degree of psychic dependence, and some may produce physical dependence as well. For our purposes, we can follow the World Health Organization's phraseology and define physical dependence as an adaptive state characterized by intense physical disturbances when administration of the drug is suspended, and psychic dependence as a psychic drive that requires periodic or chronic administration of the drug either for pleasure or to relieve discomfort.

Narcotic drugs

The narcotic drugs include opium and its derivatives, morphine, codeine and heroin, and other drugs that are like the opium derivatives in their action. Through repeated administration, these drugs produce both psychic and physical dependence. In Canada the most frequently used drug in this group is heroin. Because of their relatively long history of non-medical use, there is a body of knowledge concerning addiction to these drugs that is more extensive than for any other group of non-alcoholic drugs.

It is evident from Table 9 (next page) that this condition is relatively rare, particularly if compared with the prevalence of alcoholism.

From 1924 to the Second World War there was a steady decrease in these addictions, and since the end of the war the absolute number of narcotic addicts has scarcely changed. This condition is almost entirely restricted to large cities: Vancouver, Toronto and to a lesser extent Montreal account

for more than 90 per cent of all cases. Narcotic addicts are largely recruited from the lower socio-economic groups, and are generally much younger than alcoholics. The explanation for the difference in age is probably that addiction to narcotics develops very rapidly, and older addicts tend to discontinue the use of drugs. This spontaneous cessation has been termed "maturing out," implying that it typically occurs after many years of addictive use.

TABLE 9
Estimates of the Number of Narcotic Addicts,
Canada, 1924 to 1966

Year	Population	Estimated Number of Addicts	Percentage of Population Addicted
1924	9,200,000	9,000	0.10
1929	10,000,000	8,000	0.08
1939	11,300,000	5,000	0.04
1943	11,800,000	4,000	0.03
1948	12,800,000	3,000	0.02
1955	15,500,000	2,300	0.01
1956	16,100,000	2,600	0.02
1961	18,200,000	3,000	0.02
1966	19,900,000	3,100	0.02

The prevalence estimates of narcotic addiction in the United States range from 46,000 to 200,000. All these estimates are, according to their authors, conservative and reasonable. It is impossible to attribute a higher or lower credibility to any of these estimates, but it is generally agreed that the United States leads in the magnitude of this problem among Western countries. As in Canada, no significant increase has occurred over the last few years. It may be of interest that current estimates of the number of alcoholics in the United States run as high as 6,000,000. Clearly, with

respect to the number of persons affected, narcotic addiction is far less important than alcoholism.

Depending on the dosage, barbiturates can depress the central nervous system to any degree desired, from sedation to anaesthesia. Dependence on barbiturates arises from their repeated administration on a continuous basis, generally in amounts that exceed the usual therapeutic dose levels. There is a strong desire or need to continue taking the drug, not only as a result of a subjective appreciation of its effects, but also as a result of physical dependence: the presence of the drug becomes necessary to avoid abstinence symptoms.

It has been estimated that about one-half of all barbiturates produced in North America are diverted to the illicit market. Although attempts have been made to determine the size of the population of habitual abusers, it is unlikely that these estimates reflect the true prevalence. However, there is general agreement—based on production statistics and mortality rates involving barbiturate consumption—that the non-medical use of this group of compounds has risen markedly over the last few years.

Mixed addictions

The question of magnitude is further complicated by concomitant addictions to heroin and alcohol. Some heroin addicts are currently using barbiturates, and it has been known for some time that many alcoholics are also dependent on these drugs. In some studies it was found that habituation to barbiturates was particularly frequent among members of Alcoholics Anonymous and among other alcoholics during prolonged periods of abstinence.

The amphetamines, and other drugs with similar pharmacological properties, induce a state of well-being and elevated mood. The abuse of this class of drugs probably originates in, and is perpetuated by, a desire to achieve euphoria. Although the amphetamines do not induce physical dependence in the pharmacological meaning of the term, with-

drawal from large dosages is by no means symptomless. The use of amphetamines by self-administration has increased consistently in recent years, particularly among persons who also abuse alcohol or barbiturates or both. In most instances there is dependence on more than one drug.

Medical addiction to amphetamines?

To estimate the prevalence of amphetamine abuse is difficult. There are no accurate figures, and no careful studies have been done. Some investigators have suggested that as many people may have become seriously dependent on amphetamines as on narcotics. A much larger number of persons may have become dependent on amphetamines in the course of medication for depression. The majority of these are middle-aged, many of them women, for whom these drugs were originally prescribed by their physicians.

The World Health Organization uses the term "drug dependence of cannabis type" to denote dependence on all cannabis (hemp) products, including hashish and marihuana. Among the more prominent subjective effects of cannabis, for which it is taken periodically or chronically, are hilarity, euphoria—sometimes with increased sociability as a result—and distortion of sensation and perception, especially of space and time. Typically the abuse of cannabis is periodic, but even during chronic administration no evidence of physical dependence can be detected. There is, in consequence, no characteristic withdrawal syndrome when cannabis use is discontinued. Psychic dependence may develop from continuous administration over a long period of time.

Prevalence of marihuana use

Although marihuana use has been reported in North America throughout this century, its prevalence appears to have decreased considerably during the Second World War and the immediate post-war years. According to many reports, there has since been a recurrence of interest in cannabis—

particularly among adolescents and university students. Some isolated surveys report that up to seven per cent of all students have smoked marihuana; however, a close investigation of these reports indicates that most of the subjects who were counted as users had no record of continuous or periodic use. A careful search of the literature has suggested to me that it is impossible to make a reasonable guess about the number of marihuana users in Canada, or for that matter, in any other country. Similar difficulties apply if one attempts to describe the user population. In some parts of the United States, marihuana smoking is most prevalent among Negroes and other minority groups. Some investigators have suggested that it is used mainly by persons in the lower socio-economic strata of society, while others have suggested widespread use among students.

Patterns of LSD use

Lysergic acid diethylamide (LSD) is taken for thrills, to alter mood, to change and clarify perception, or to induce reveries. Generally it is used in a single dose or in several doses over a period of two or three days. Periodic use in the company of others appears to be the typical pattern, rather than prolonged or continuous use. Although psychic dependence on LSD may develop, is usually not intense. If LSD is not readily available to a person accustomed to its use, he will be able to do without it and not experience undue discomfort.

LSD has received wide publicity and, according to some investigators, possesses a particular attraction to "creative" people, such as writers, painters and musicians. Others have suggested that LSD users appear to be a young population of male students, former students and college graduates in their early 20's. All the studies on illicit LSD use come from large cities, such as Los Angeles, New York, San Francisco and Boston, with the exception of a single report from a small university city, Chapel Hill. Although it cannot be

assumed that LSD is being used only in these cities, its connection with urbanism and university facilities is probably not an artefact of the reporting that has been done so far.

LSD has not been available long enough to establish the prevalence of its use with any degree of reliability. To my knowledge, the only survey on this subject was conducted at the University of Southern California. The authors of this study found that 3 per cent of a sample of students reported experience with the stronger hallucinogens, which include peyote and LSD, and only one student out of 121 had taken LSD. Most of the "user" group had limited their experimentation to one or two trials.

U.S.C. criteria different?

These incidence figures are quite low compared to the estimated rates among students of certain other universities of comparable size. There is no apparent reason why the University of Southern California should differ from the universities at which a higher prevalence of hallucinogenic drug-taking has been reported. The most plausible explanation for the relatively low rate found in the U.S.C. survey is that it represents an actual count of users, whereas the higher rates reported elsewhere are estimates based on impressions.

In the case of LSD, as well as the other hallucinogen discussed in this paper, the concern is not so much over its present prevalence, which is probably still relatively low; there are convincing indications that illicit drug use generally is increasing, particularly among younger people. It is still too early to predict future trends, but the long history of use of some of these drugs and their spread over most of the world, despite stringent prohibitive laws, suggest that these practices will continue for some time to come.

A.I.T. Addictions

SCI MED. DIV.

JAN 16 1969

University of Toronto

WINTER, 1968

Volume 15, Number 4

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ADDICTIONS is published four times a year by the Addiction Research Foundation, an agency of the Province of Ontario.

The contents of each issue are selected on the basis of their potential interest to persons engaged in research, treatment or education in the field of alcoholism and drug addiction.

Articles published in ADDICTIONS do not necessarily reflect the views of the Foundation.

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Editor: Alasdair McCrimmon

PRINTED IN CANADA

Authorized as second class mail by
the Post Office Department, Ottawa,
and for payment of postage in cash.

A.I.+. Addictions

Volume 15, Number 4

Winter, 1968

Medical Treatment and Study of Alcoholism

By Paul Devenyi, M.D.

The expression "disease concept of alcoholism" is attributed to the late E. M. Jellinek, who wrote a book with that title;¹ but it is really not the invention of any one man. Actually, the concept evolved over the last two or three decades as an economical expression of society's concern and responsibility for trying to solve this vast problem. In the process, the disease concept has become an almost commonplace slogan, to which many people pay lip-service without really accepting it. Nevertheless, the concept serves a useful purpose in expressing our belief that alcoholism is a "respectable" problem—a problem that deserves professional and scientific attention, and a problem from which recovery is possible. The disease concept may be helpful to those who suffer from alcoholism themselves, since it may be easier to accept than moral recriminations. It is also in keeping with our

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sophisticated present-day view that any form of deviance—from bank robbery, through rape, to murder—is a manifestation of sickness.

Concept created problems

The disease concept of alcoholism stirred up society's interest in doing something about the problem, promoted the development of research and treatment facilities all over the world, and drew a good number of outstanding professionals into the field; but it created as many problems as it solved. Professionals began to argue whether, in fact, alcoholism can justly be called a disease, or whether it is really a behavioural disorder or perhaps a social problem. This led to arguments about who is best qualified to deal with it—the medical doctor, the psychologist, or the social scientist?

Then came what has been called the "team approach." On the one hand, this approach realistically emphasized that such a complex disorder as alcoholism cannot be regarded as the exclusive territory of any one profession; but on the other hand, it has thrown together a number of professionals who view and handle the problem from their own narrow points of view without being able to communicate with each other. We still keep insisting that alcoholism is a disease; yet, as Thomas Plaut said in 1964,² "we turn over . . . much of the responsibility for its treatment to a group that is not only non-medical but also non-professional!"

The disease concept, many would argue, may not even be as useful from a therapeutic point of view as it seems. It may be an added excuse for continued drinking: "I drink because I am sick; there is nothing I can do about it." I am sure many of us know a number of alcoholics who capitalize on the disease concept in that way and refuse to accept any responsibility for their condition.

But the group for which the disease concept has created

the most problems is the medical profession itself. "Alcoholism is a disease" may be a very nice statement for public consumption; but once something is declared a disease, then there is an implication that it is up to the doctor to treat it, and that the doctor will be able to treat it with some prospect of success. Here we have created a gap between society's definition of alcoholism as a disease and the doctor's willingness to deal with it. The medical profession today is less ready to accept the disease concept than is the public at large. Even though the executive of the American Medical Association has declared alcoholism a disease (the Canadian Medical Association has not), physicians by and large feel that the whole problem has been thrown into their laps without their wanting it.

The doctors' dilemma

Robert Strauss, sociologist and alcoholism expert from Lexington, summarized this dilemma ten years ago.³ He said that doctors are not taught about alcoholism as a clinical entity: they find it an elusive clinical phenomenon that has neither a well-defined diagnostic picture, nor a common etiology, nor a characteristic course, nor an accepted way of management. Social, economic and psychological problems are involved, which are beyond the doctors' sphere of competence. Treating alcoholics is an unrewarding experience: they demand ever more attention—usually at inconvenient times; they do not keep appointments, they do not pay their bills, and they do not get well. Intellectually the doctor accepts all the traits of the alcoholic as a disease, but emotionally he finds it difficult to maintain professional objectivity. In addition, he has to face the very practical dilemma of not knowing how to help the patient.

Strauss saw the solution of this dilemma in what we call today "comprehensive medicine." This approach emphasizes that the concepts of health or illness are not restricted only to man's organ systems but include his personality,

social interactions, customs and beliefs. A new generation of physicians, brought up in this spirit of medical education, may be more responsive to the problems of alcoholism; but this is still not the case today. A decade after Strauss made his observations, the situation is not any different.

A community problem

Harold Mulford, Professor of Sociology and Psychiatry at the University of Iowa, expressed the problem eloquently in a recent address to the North American Association of Alcoholism Programs.⁴ Mulford remarked that alcoholism is difficult to diagnose and identify. One treatment may be as good as another; indeed, there is no conclusive evidence that any treatment is better than no treatment at all. Further, he said, "asking busy physicians to apply a treatment that does not exist, to an illness that has not been defined, in a population that does not want to be bothered, is not fair to the doctor and is not likely to solve the alcoholism problem." He strongly advocates de-emphasizing the disease concept and moving away from the medical model of alcoholism. He views alcoholism as a local community problem, which can be solved only by local community-action programs.

All I have said so far might be taken to indicate that one cannot assign a very large role to the medical profession in the management of alcoholism. This is not so. I have just tried to express the difficulties the medical profession faces within the oversimplified context of the disease concept. We are perhaps reaching a more realistic stage today, when we do not have to argue about whether or not alcoholism can be called a disease: we can just say that we are dealing with a complex, multi-faceted disorder in which medicine, among the other professions, has a major role to play; but we have to define this role within the limits of reality. In the following, I would like to discuss how I personally see this role.

In the spring of 1967 our Foundation established the Medical Care Unit (nicknamed the Hastings Unit), which is a 32-bed hospital for the treatment and study of alcoholism and other addictions. This unit was conceived as a pilot project which would develop into the nucleus of the Foundation's new hospital, now under construction. The unit is primarily concerned with acute treatment, withdrawal management, treatment of complicating or associated illnesses, and restoring the patient's physical—and, to a certain extent, his mental—well-being, thus making him more amenable to long-term management. Because of the nature of the unit, the research that goes on there is primarily medical—but not entirely. The patient material is available, and is being used for social, psychological and religious studies as well.

The research function

I would like to discuss the research part of the unit's function first, although this does not necessarily mean that we attach more importance to research than to treatment. We have been developing a data-collection system that concerns not only the patient's medical status but also his social characteristics, psychiatric and psychological status, and his religious life. This is done in a way that assures retrievability. Some may attack this approach on the grounds that it is research *per se* and that there is no point in collecting a lot of data if we do not know beforehand what we are going to do with the data. However, we do not regard this data-collection system as research, but rather as storage of all obtained material and information in a retrievable form so that it may be readily available for any future research project, either by our own staff or by anyone else in the Foundation.

We have a large population of alcoholics going through this unit, and we felt that we cannot afford to lose all the valuable information we are gathering about them. Just think of the traditional patient files in this Foundation. We have

thousands of them—many of them big, thick volumes. Each one of these files contains a vast amount of good information buried and lost among long, loquacious dictated notes, which often contain momentary episodic details of the patient's everyday life but which are irrelevant from the point of view of posterity. It is difficult enough to get a good overview from such a file, even about one individual patient; and it would be next to impossible to use, say, five hundred such files for the purpose of a study.

An evolving process

This is the reason why we decided to put all extracted data on a preconstructed check-list, from which they can be transferred and stored in a computer and retrieved quickly in any desired combination. This is being done in addition to the traditional record-keeping system, and I can say that it is well worth the extra effort. We have already enjoyed the advantages of this system for some of the special projects already under way in the unit, to which I will refer soon. The problem is, of course, what to feed into the computer. The development of such a system must be a gradually evolving process, which requires ever-continuing improvement.

Now we can turn to some of the special studies that are going on in our unit. As I mentioned, not all projects are medical in nature in spite of the fact that we call our facility the Medical Care Unit; but because of the title of this presentation I would like to single out some of the medical research work as examples of the medical profession's possible contribution to the study of alcoholism.

The effect of alcohol on the mucous membrane of the stomach has been investigated for some time by many workers. It is known that low concentrations and small doses of alcohol increase stomach secretion and actually improve appetite; the use of alcohol as an appetizer is based on this observation. On the other hand, large doses and high con-

centrations of alcohol are actually damaging to the gastric mucosa and produce acute gastritis, evidenced by loss of appetite, vomiting, bleeding and other symptoms. If the damage is prolonged, chronic gastritis will set in; this is one condition that our group decided to investigate. On a series of gastroscopic examinations, including biopsies, we found atrophic gastritis in 5 to 10 per cent of cases. This is chronic gastritis with atrophy of the mucous membrane and some destruction of the peptic glands—the stomach glands that secrete the digestive enzyme known as pepsin.

It has been established that alcohol does not cause peptic ulcers; but, by its irritating or secretion-stimulating effect, it may make existing ulcers worse. We have been impressed by the relatively large number of our alcoholic ulcer patients who have had gastric surgery. More than half of those with a previous history of ulcer had undergone operations; I am sure this is a much higher incidence than you would find in the general ulcer population in a day and age when uncomplicated ulcers are generally managed by conservative means.

Cirrhosis over-diagnosed

The involvement of the liver is another one of our interests. Among all the organs and systems that may be affected by alcohol, the liver stands out as the chief concern of patients and physicians alike; and it is the principal target of medical research. From a clinical point of view, over-diagnosis is generally more common than under-diagnosis. This is especially true of cirrhosis, which as a diagnostic label is affixed to a large number of alcoholics who in fact have only a fatty liver. We consider fatty liver a transient and entirely reversible condition, which appears when active drinking takes place and disappears with abstinence and good nutrition. It is characterized by an enlarged and sometimes tender liver, with some other abnormalities that show in laboratory tests; all these abnormalities seem to disappear

when the patient stays away from alcohol for a few weeks.

We have done liver biopsies on 100 randomly selected alcoholics—all of them drinking up to admission—and found that about two-thirds of them had fatty livers. We have found no connection between the nutritional status and nutritional habits of our patients and fatty livers. This clinical finding supports the experimental findings of Lieber and Rubin⁵ that fatty liver is caused by the toxic effect of alcohol itself, contrary to the older notion that it is caused by nutritional deficiency.

Who gets cirrhosis?

Another old contention, that fatty liver leads to cirrhosis, is also in doubt today. Cirrhosis of the liver is a condition characterized by destruction of liver cells, their replacement with scar tissue, and the formation or regeneration of new but imperfectly formed liver cells. It is a serious and chronic disease, directly or indirectly leading to death. It is true that the incidence of alcoholism among cirrhotics is high, but it is also true that the incidence of cirrhosis in any alcoholic population is relatively low. We found 2 per cent in our 100 biopsy cases, and less than 1 per cent confirmed cases of cirrhosis in our entire clinic population. Since the majority of alcoholics develop transient fatty liver but only a few of these develop cirrhosis, we cannot say that fatty liver leads to cirrhosis. Something else than alcohol or nutritional deficiency is necessary for the development of cirrhosis—perhaps a constitutional or genetic predisposition that we do not understand as yet. We are particularly interested in trying to pick the ones who will develop cirrhosis—in trying to spot some predicting factors. Now that we have base-line information, including biopsies, on 100 patients, we are embarking on a follow-up program with this group. We are rebiopsying them after the lapse of one year or so and trying to assess their progress in terms of liver damage—correlating it to the previous biopsy, to clinical laboratory

findings and to their drinking or abstinence between the two biopsies. We believe that this will be a unique study and may be an important contribution to the understanding of the relationship between alcohol and the liver.

Other work that is being done concerns the improvement of some of the liver function tests. For example, one of the standard liver function tests is the BSP retention test. BSP is a dye of which a standard dose given intravenously is normally removed from the blood by a healthy liver in 45 minutes. The amount of dye retained in the blood after 45 minutes is a quantitative indication of liver function impairment. We found, however, that a number of patients who showed clinical evidence of liver damage still showed normal BSP retention values. This prompted our laboratory director to try to improve the sensitivity of the BSP retention tests, by giving a larger dose and taking the reading after two hours instead of 45 minutes. After we established normal values on controls—mainly volunteers from our own staff—we found that this test was more sensitive than the traditional test; it was capable of detecting abnormalities where the usual method failed to do so.

Alcoholism and the heart

One other area that may be of interest is the involvement of the heart. Several observations have been made indicating that the incidence of coronary artery disease and high blood pressure may be less in alcoholics than in the general population. This contention is being tested in our unit; if it is true, it may be that the generally poor nutritional habits of alcoholics have something to do with it. Similarly, our dental consultant found surprisingly little tooth decay among our alcoholics in spite of their generally poor oral hygiene. Here may be one area where drinking too much or eating too little, or both, has some advantage.

On the other hand, alcohol may have some direct damaging effect on the heart muscle itself. I am not talking here

about the isolated epidemic of the Quebec beer drinkers whose heart damage was attributed to a cobalt contaminant in the beer, nor about beriberi heart due to vitamin deficiency; I am talking about the direct cardiomyopathy—disease of the heart muscle—caused by alcohol, as described by Evans.⁶ We have had a small but sizeable group of patients, admitted immediately following a drinking bout, in whom we found electrocardiographic abnormalities that disappeared after a few days of abstinence. In some instances, we were able to reproduce the same ECG abnormalities by giving the patient an alcohol infusion; again, the ECGs became normal in a few days. Here we face the same perplexing question that we discussed in connection with cirrhosis: why some and not others? This again is an area that deserves further observation and study.

Much psychiatric research

These examples probably make it clear that medical research in connection with the excessive use of alcohol has a lot of territory to cover. I have not mentioned psychiatric research, because it is beyond my area of competence; but I consider psychiatry very much a part of medicine and there is a lot of work being done in this specialty, both in our unit and elsewhere.

Now I would like to discuss the other main objective of the Medical Care Unit—the treatment objective. When we talk about the treatment of alcoholism we are getting into a sensitive area, since many people would argue that there is really no treatment available other than trying to persuade the alcoholic to give up drinking: in effect, appealing to his capacity of spontaneous recovery. Various methods are being used in trying to assist patients to bring this recovery about, but no one method is specific: we do not know of any therapy that would be as specific for alcoholism as, for instance, penicillin is for pneumococcal pneumonia.

Although there may be no one specific treatment, we

cannot doubt that various manipulations and various forms of therapeutic intervention may significantly contribute to the recovery of these patients—recovery that otherwise might not take place. That is why clinics are being set up and attempts are being made to keep alcoholics sober and get them to function adequately in their environment. This is the area that we call long-term management, and it specifically refers to keeping a sobered-up alcoholic sober and adequate. This is where many professionals—doctors, psychiatrists, nurses, psychologists, social workers, clergymen, probation officers and others—come into the picture. But this long-term management phase is preceded by what we call the acute phase, when the patient is acutely ill from the recent abuse of alcohol; this is a phase in which the medical profession has a primary responsibility. We in our unit are dealing mainly with acutely ill individuals—individuals suffering either from acute intoxication or from acute withdrawal.

Acute alcohol intoxication I do not have to describe to you. As far as its treatment is concerned, over-treatment is much more possible than under-treatment. Our chief concern should be to provide for the patient's safety, to interrupt his drinking, and to let him "sleep it off" while he burns up his accumulated alcohol. Whether this takes place in a hospital or at home depends on the circumstances.

Stimulants may be dangerous

I would warn against the application of stimulants such as caffeine or amphetamines, since they do not add anything to the sobering-up process. They may even be dangerous because, as Leon Greenberg of Rutgers has pointed out,⁷ by giving a stimulant you will have a "wide-awake drunk" instead of a "sleepy drunk"—but drunk he still will be. A wide-awake drunk is more dangerous because he may go out and get involved in all sorts of activities, he may drive a car, he may drink more; whereas the sleepy one will

sleep and while he sleeps he will oxidize his alcohol. There is only one exception, and that is the severe condition of alcoholic coma. In this situation stimulants are used—not to stimulate the patient, but to stimulate his respiration.

When sedatives may kill

We have also to caution against the uncritical use of sedatives and tranquillizers in an acutely intoxicated person. Alcohol itself is a central-nervous-system depressant in spite of the fact that an intoxicated person often appears to be agitated, aggressive and stimulated. If you add another CNS depressant to the one already present, you may have unpredictable consequences, since one may potentiate the other; you may have the situation where two plus two is not four but five, and in some instances you may kill your patient. Koppanyi⁸ described the case of an acutely agitated intoxicated patient who was given intravenous sodium amytal and died immediately of respiratory arrest. Similar cases are reported from time to time. We find that most intoxicated patients, no matter how irrationally violent they are, can be managed without sedation by avoiding argument and getting them gently to bed; left alone, they will fall asleep without any medication. We meticulously avoid any CNS-depressing drugs in patients whose blood alcohol level exceeds .15 per cent.

A rational therapeutic approach would be to apply drugs that would speed up alcohol metabolism, helping the patient to sober up more quickly. Unfortunately, we know of nothing that could do this with any reliability. Marshall Goldberg⁹ used a thyroid preparation with which he claimed success, but others such as Harold Kalant¹⁰ in our own Foundation could not reproduce his findings.

Intravenous administration of insulin and glucose may have a theoretical rationale, because it produces pyruvate which can remove hydrogen from alcohol and combine with it to form lactate. Hydrogen acceptors are important, because

this is how alcohol is oxidized. The so called NAD coenzyme is the chief acceptor, but its supply is limited; the pyruvate produced by insulin and glucose may supplement it. It sounds good in theory, but in practice pyruvate does not oxidize alcohol quickly enough to be helpful under clinical conditions. I would still maintain that there is nothing we can do that will reduce the blood alcohol level at a rate significantly faster than the spontaneous rate of .015-.02 per cent per hour.

Our next consideration is management of the alcohol withdrawal syndrome—which is a far more serious condition than the simple hangover that most of us have experienced after a good night out. When we talk about the withdrawal syndrome, we mean a definite acute illness that follows an episode of the very heavy drinking that is characteristic of alcoholics. It is the sequel to acute intoxication: the blood alcohol level has fallen; and the brain, released from the depressant effects of alcohol, rebounds into the other extreme of hyperexcitability. In its mildest and commonest form, it appears as a tremor—the shakes; in more severe cases it appears with hallucinations, convulsions like those one sees in epilepsy, or, in the most severe form, as delirium tremens.

When sedatives are the key

Sedatives must be used with caution in cases of acute intoxication; but in the withdrawal stage adequate sedation is the key to effective management. The choice of sedative is largely a matter of individual preference. You will find many studies in the literature; in each one, the authors claim that the method they use is superior to all the others. Of course, we too have our claim: we prefer the benzodiazepine drugs such as chlordiazepoxide and diazepam—chlordiazepoxide being the one we mainly use. We start with fairly high doses if necessary, such as 100 mg. intramuscularly—occasionally even intravenously—every hour or two, then switch to oral

administration and gradually reduce the dose to 50 and later 25 mg. three or four times a day.

We prefer benzodiazepines to the phenothiazine type of drugs because benzodiazepines are fairly safe, they do not cause a sudden drop in blood pressure which phenothiazines may do, and they have a muscle relaxant as well as some anticonvulsant effect—whereas some of the phenothiazines may even promote convulsions. There are very few adverse side effects; we have found ataxia and drowsiness a problem in some cases, but it disappears when the dose is reduced. We judge this treatment very effective, since in about 700 acutely ill alcoholics we did not have a single case of convulsions and hardly any DT's; and so—fortunately or unfortunately—we were unable to show examples of these conditions to our young nurses and medical students.

Avoid barbiturates

Some workers, such as Richard Bates of Lansing, Michigan,¹¹ still prefer the use of barbiturates in acute withdrawal. We ourselves avoid barbiturates in all phases of the treatment of alcoholism because of the high incidence of associated barbiturate abuse among our alcoholic patients. Haloperidol is another excellent tranquillizing drug, mainly used with agitated schizophrenics, which has also been used in alcohol withdrawal. We have given it in a few cases, but have not much experience with it. Europeans, especially French and Scandinavian workers, often use chlormethiazole in the treatment of DT's. The problem with this drug is that if you cannot give it by mouth you have to give it by continuous intravenous infusion and regulate the dose according to the patient's response. This is a difficult procedure with a delirious patient, and would hardly win the ordering doctor a popularity contest among the nursing staff.

We do not use anticonvulsants routinely, but we always give them when there is a history of previous convulsions. Some workers use magnesium sulphate in the management

of DT's, following Mendelson's work in Boston¹² and Nielsen's in Denmark,¹³ who demonstrated consistent magnesium deficiency in DT's; but we do not use it. The administration of vitamin supplements, especially the B complex, is a reasonable treatment in the acute phase if we assume that most alcoholics eat less or not at all while drinking and thus suffer from nutritional deficiencies. Members of the Vitamin B group are important coenzymes in various metabolic processes and are valuable in the treatment or prevention of such deficiency diseases as peripheral neuropathy or Wernicke's encephalopathy. I believe, however, that in the absence of any specific deficiency disease the long-term use of vitamins beyond the acute stage is not necessary and helps only the vitamin manufacturers. A well-balanced diet is the best source of vitamins.

I ought to say a word about one of the most popular remedies for alcohol withdrawal symptoms—the one used most often by alcoholics: alcohol itself. It is certainly very effective for immediate relief of the shakes. The trouble is that it is generally used erratically and only serves to perpetuate the vicious circle of drinking. As a medical treatment, "tapering off" with intravenous alcohol is not much in use any more, although it is not entirely unreasonable and perhaps has not been fully investigated in a scientific manner.

Complicating illnesses

Once we have effectively controlled the withdrawal symptoms, and often while they are still going on, we have to pay attention to certain associated or complicating illnesses the alcoholic may suffer from. Some of them may be at least indirectly due to alcoholism, such as neuropathy, encephalopathy, or liver cirrhosis; respiratory infections also are fairly frequent among alcoholics. Other conditions may be totally incidental and independent from alcoholism, but we have to treat them: we are not treating alcoholism only, but alcoholic persons. Restoration of the patient's physical

health may have some bearing on his long-term progress. One example was a patient we had in our unit recently who had Addison's disease—insufficient function of the adrenal glands. Now this has nothing to do directly with alcoholism, and we could have said that this part of his problem was none of our business; but by diagnosing and properly treating this condition we can relieve his weakness, lassitude and loss of appetite, and he stands a better chance of staying away from alcohol than if he felt miserable all the time.

Need for long-term management

Suppose we have a patient who has been with us a few days, his intoxication and subsequent withdrawal syndrome have been effectively treated, his physical health has been restored, he feels fine and ready to go home. If this is all we have done, we have just made him physically fit and ready for his next drinking bout. This is what often happens in general hospitals: the patient is discharged as soon as his physical problems have been dealt with, and no attempt is made to channel him towards some sort of on-going treatment or supervision or rehabilitation. Predictably, this patient will be back in the emergency room very soon—much to the disgust and frustration of the hospital staff. I do not mean to say that many of our patients do not behave the same way; but at least we try—and everybody should—to make some early effort towards the maintenance of their sobriety and their effective functioning. This early phase of long-term management should be an integral part of acute treatment; we must keep in mind that the motivation on which we have to capitalize is at its peak immediately after an acute drinking bout. I would just mention three possibilities here, which we have at our disposal.

The patient may need more psychoactive drugs in the post-acute period. We have to think seriously about the possibility that we may only make him dependent on another chemical; but judicious use of anti-depressants or tran-

quillizers, or both, may help him in his early adjustment. Perhaps in most cases this would only be necessary for a short period of time, in some cases longer, and in some cases not at all. I would certainly avoid highly dependence-producing drugs such as barbiturates; and in this phase I would rather use phenothiazines instead of chlordiazepoxide if longer treatment is anticipated, since physical addiction to phenothiazines is not known to occur.

The administration of a protective drug—Antabuse or Temposil—can be a valuable aid to long-term management. It is wise to start it while the patient is still in hospital—in the immediate post-acute period, when his willingness to take it is at its peak. We do not push the issue, but we offer one or the other to all patients—with ample explanation; if they accept it, we begin to give it to them for a few days before they leave the hospital.

Finally, as I have suggested, one should make an effort to see that the patient is not just discharged with nowhere to go, but that he will get some sort of support, supervision, psychotherapy, or whatever he may need: in other words, to channel him towards some kind of long-term management facility.

Conclusions

In conclusion, I would like to sum up some of my personal views about the role of the medical profession in the study and treatment of alcoholism. As far as research is concerned, medicine has contributed a great deal to this field in the past and will continue to do so in the future. It may be that the social, economic and psychological damage that alcoholism causes is much more widespread than the physical damage, but the latter is still important to those who suffer from it.

So far as treatment is concerned, I believe that acute treatment is mainly the responsibility of the medical profession; the role of other disciplines is necessarily limited at

this stage. In fact, I believe that the medical profession—and this would include hospital administration—must undertake this responsibility. But once we have dealt with the acute phase, the non-medical professional will assume an increasing role in maintaining the patient's sobriety and his effective functioning in society.

Perhaps it is more realistic to define the role of the medical profession in this way, rather than throwing the whole problem at them by the unqualified definition of alcoholism as a disease. One would still hope that more and more physicians—especially psychiatrists and family practitioners—would assume responsibility in the multi-professional team effort of long-term management, either in their private practices or by joining specialized facilities that deal with alcoholism. This way we could find alliance with the other helping professions. As Kessel and Walton have said,¹⁴ "Two things are required to produce an alcoholic: the drink and the person. Restriction of supply is a debatable matter, but helping the vulnerable person is a civilized and a merciful act open to us all."

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Changes of Address

New postal rates announced recently by the Postmaster-General result in a substantial increase in *Addictions* mailing costs. Charges for the return of undeliverable copies, for instance, have jumped to ten cents a copy from the former rate of two cents.

Our readers can help keep such charges to a minimum by notifying us promptly of any change in address.

Alcohol and Sexual Performance

(1)

MACDUFF: Was it so late, friend, ere you went to bed
That you do lie so late?

PORTER: Faith, sir, we were carousing till the second
cock. And drink, sir, is a great provoker of three things.

MACDUFF: What three things does drink especially pro-
voke?

PORTER: Marry, sir, nose-painting, sleep, and urine.
Lechery, sir, it provokes and unprovokes. It provokes the
desire, but it takes away the performance. Therefore much
drink can be said to be an equivocator with lechery. It makes
him and it mars him, it sets him on and it takes him off, it
persuades him and disheartens him, makes him stand to
and not stand to; in conclusion, equivocates him in a sleep
and giving him the lie, leaves him.

—William Shakespeare, *Macbeth*,
Act II, Scene iii (1606).

(2)

The aging male's excessive consumption of either food
or drink has a tendency to repress his sexual tensions as it
also lowers his capacity to feel or achieve in other areas.
Many males have reported diminution of intensity in sen-
sual focus, sometimes to a degree of anesthesia, as a result of
overeating. However, the repression of sexuality is transient
in nature unless the individual's eating patterns are grossly
excessive and on a constant basis.

The syndrome of overindulgence has particular appli-
cation to alcohol. While under its influence, many a male
of any age has failed for the first time to achieve or maintain
an erection of the penis. Secondary impotence developing
in the male in the late forties or early fifties has a higher
incidence of direct association with excessive alcohol con-

sumption than with any other single factor. When a man is traumatized by the inability to achieve or to maintain an erection while under the influence of alcohol, he frequently develops major concerns for sexual performance and rarely associates his initial disability with its direct cause.

Not only does high alcohol ingestion directly reduce sexual tension in the aging male but also it often places upon him the additional indirect burden of concern for performance. He usually faces this secondary psychologic problem, if it persists, either by partial withdrawal from or by total avoidance of marital sexual exposure. His frequent solution to his erective concerns is to seek a sexual source unfamiliar with his personal concerns of sexual inadequacy. If, coincidentally, he refrains from adding excessive alcohol ingestion to the occasion of the first coital opportunity with the new partner, his solution probably will work. Thus a new problem within the marriage may arise. He is impotent with his wife but has confidence in his sexual performance elsewhere.

The alternative to the alcohol-dependent male with an impotence pattern is the picture of the true alcoholic. As this male progressively deteriorates physically and mentally, his sexual tensions simply disappear.

—William H. Masters and Virginia E. Johnson, *Human Sexual Response*. Boston: Little, Brown and Company, 1966.

May Street Centre to Open Early in 1969

In close collaboration with a group of private companies and the Ontario Department of Civil Service, the Addiction Research Foundation plans to open a special centre for employed alcoholics early in 1969. It will be located at 8 May Street in Toronto's Rosedale district and will be housed in a converted mansion that was formerly used as a private hospital.

The centre is being established as a pilot project and demonstration unit. It will be used to test and demonstrate methods of working with employers in evolving referral, treatment, and follow-up programs for employees whose drinking patterns are interfering with their job performance. Responsibilities of the centre will be three-fold: treatment, evaluation, and education.

Gradual buildup

The centre will build up its operations gradually. Initially it will provide out-patient services, some group therapy, and orientation programs for employers and union officers. At later stages, it will become involved in overnight care for people who work during the day, in-patient services on weekends, and eventually full in-patient services.

Earl Patton, a former senior executive at Bell Telephone who is serving as the centre's pro tem director, emphasizes the experimental nature of the program: "Our purpose is to show what can be accomplished by referral and treatment of employed alcoholics under optimum conditions—and to keep complete records of the process. This should prove immensely useful in convincing management and union people of the value of policies and procedures for bringing problem employees into treatment." The intention is to experiment with methods for training supervisors and for orienting entire staffs as well as with methods of treatment and follow-up.

"If employers can be shown that this idea works and that the concept is worthwhile from the point of view of work potential and conservation of trained manpower, they might be stimulated to take the initiative in dealing with this serious social and health problem." Employers must realize that the problem cannot be sloughed off: "Over fifty per cent of the problem drinkers in Ontario are employed people; yet even now there is a tendency in many firms for senior management to approach alcoholism reluctantly and to avoid confronting it as long as possible."

Attitude changing

That this attitude is changing is clear from the collaboration of a group of major Ontario employers in the project at 8 May Street. Bell Telephone, B.A. Oil (Gulf), Canadian Kodak, Ontario Hydro, and the Ontario Civil Service—all with established programs for treating alcoholism among employees at all levels—have cooperated actively with the A.R.F. in setting up the centre. Mr. Patton emphasizes that management cooperation is essential to the program's success—"and this means management at its highest levels. No less essential is the active cooperation of organized labour."

Intensified Programs in Midwestern Ontario

The Addiction Research Foundation is beginning an intensified alcoholism and drug dependence program in the Kitchener-Waterloo metropolitan area and is expanding facilities to serve the counties of Waterloo, Brant, Norfolk, Wellington and Dufferin. Three distinct but related programs are being developed concurrently:

- based in Kitchener and Waterloo, covering Waterloo County with a population of 225,000;

- based in Brantford and Simcoe, covering Brant and Norfolk Counties with a population of 140,000; and

- based in Guelph, covering Wellington and Dufferin Counties with a population of 125,000.

The Kitchener-Waterloo program involves development of a new addiction centre and a number of specialized services including information, consultation, counselling, and referral assistance.

An A.R.F. community consultant is surveying Brant and Norfolk Counties prior to recommending a specific program to coordinate existing community resources. The county health units have made facilities available to him.

The program in Wellington and Dufferin Counties is run independently by the Wellington-Dufferin-Guelph health unit, which has assumed the responsibility of developing the program in close cooperation with the A.R.F. and with the initial support of an A.R.F. grant. This program, which will provide a network of preventive and rehabilitative services, is the first such addiction program to be operated within the framework of a public-health service in Ontario.



The Addiction Research Foundation was established in 1949 by an act of the Ontario Legislature and is financed mainly by an annual government grant. Its objects are:

- to conduct and promote research in alcoholism and other forms of addiction; and
- to conduct, direct and promote programs for:
 - the treatment and rehabilitation of alcoholics and other addicts,
 - experimentation in methods of treating and rehabilitating alcoholics and other addicts, and
 - the dissemination of information respecting the recognition, prevention and treatment of alcoholism and other forms of addiction.

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